

**ADULT SOCIAL CARE AND PUBLIC HEALTH POLICY
OVERVIEW AND SCRUTINY COMMITTEE**

Tuesday, 10 January, 2012

10.00 am

**Council Chamber, Sessions House, County Hall,
Maidstone**

***Members are asked to bring with them to the meeting a
copy of the Budget published on 20 December 2011***





AGENDA

ADULT SOCIAL CARE AND PUBLIC HEALTH POLICY OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 10 January 2012 at 10.00 am
Council Chamber, Sessions House, County
Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone **(01622) 694277**

Tea/Coffee will be available 30 minutes before the meeting

Membership (12)

Conservative (10): Mr C J Capon (Chairman), Mrs V J Dagger (Vice-Chairman),
Mr R E Brookbank, Mrs P T Cole, Mr N J Collor, Mr J M Cubitt,
Mr C Hibberd, Mr M J Jarvis, Mr C P Smith, Mr C T Wells *and one*
vacancy

Liberal Democrat (1): Mr S J G Koowaree

Labour (1): Mr L Christie

Webcasting Notice

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By entering the meeting room you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured then you should make the Clerk of the meeting aware.

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

The Committee has the option of breaking for lunch and continuing its business afterwards, if the weight of business dictates. The timing of the meeting will be determined on the day by the Chairman.

The Chairman will assume that all Members will read the reports before attending the meeting.

Item

No

A. COMMITTEE BUSINESS

A1 Introduction/Webcasting

A2 Membership - to announce that Mr J E Scholes has left the Committee, leaving a vacancy

- A3 Substitutes
- A4 Declarations of Members' Interest relating to items on today's agenda
- A5 Minutes of the meeting held on 10 November 2011 (Pages 1 - 8)
- A6 Chairman's Announcements
- A7 Oral Updates by Cabinet Member, Corporate Director of Families and Social Care and Director of Public Health

B. PRESENTATIONS

- B1 DVD of short film made by East Kent Mencap (item placed on the agenda by Mr M J Jarvis) *Jason Gerlack, Chief Executive Officer, and representatives of East Kent Mencap will be present.*
- B2 Welfare Reform – *All County Council Members have been invited to attend for this item*

C. ITEMS FOR SCRUTINY

- C1 Budget 2012/13 and Medium Term Financial Plan 2012-15 (Pages 9 - 16)
Members are asked to bring with them to the meeting a copy of the Budget published on 20 December 2011.

D. PUBLIC HEALTH ITEMS

- D1 KCC Health Inequalities Strategy Update (Pages 17 - 70)
- D2 Public Health Performance (Pages 71 - 76)
- D3 Joint Strategic Needs Assessment (JSNA) (Pages 77 - 176)

E. ITEMS FOR CONSIDERATION

- E1 Strategic Commissioning and the Transformation of Adult Social Care (Pages 177 - 182)
- E2 Interim Report of Formal Consultation on a New Service Model for Learning Disability Day Services in the Shepway District (Pages 183 - 210)
- E3 Local Account 2012 (Pages 211 - 246)
- E4 Adult Social Care Budget Forecast and Savings Report 2011/12 (Pages 247 - 250)
- E5 September 2011 Update for Performance for Adult Social Care, and Monitoring of the Projects, Developments and Key Decisions identified in the 2011/12 Annual Operating Business Plans for Families and Social Care, Adult Services (Pages 251 - 276)

F. ITEMS PLACED ON THE AGENDA BY MEMBERS

G. SELECT COMMITTEE WORK

- G1 Update on Select Committee Work (Pages 277 - 278)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

Thursday, 29 December 2011

Please note that any background documents referred to in the accompanying papers may be inspected by arrangement with the officer responsible for preparing the relevant report.

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KENT COUNTY COUNCIL

**ADULT SOCIAL CARE AND PUBLIC HEALTH POLICY
OVERVIEW AND SCRUTINY COMMITTEE**

MINUTES of a meeting of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 10 November 2011.

PRESENT: Mr C J Capon (Chairman), Mr R E Brookbank, Mr L Christie, Mrs P T Cole, Mr N J Collor, Mr C Hibberd, Mr M J Jarvis, Mr S J G Koowaree, Mr J E Scholes and Mr C P Smith

ALSO PRESENT: Mrs T Dean, Mr G K Gibbens, Mr P W A Lake and Mr R J Lees

IN ATTENDANCE: Mr A Ireland (Corporate Director, Families and Social Care), Mr M Lobban (Director of Strategic Commissioning), Mr A Scott-Clark (Deputy Director of Public Health, NHS E & C Kent), Ms P Southern (Interim Director of Learning Disability and Mental Health), Mrs A Tidmarsh (Director of Older People and Physical Disability) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS**51. Minutes of the meeting held on 20 September 2011**

(Item A4)

RESOLVED that the Minutes of the meeting held on 20 September 2011 are correctly recorded and they be signed by the Chairman. There were no matters arising.

52. Chairman's Announcements

(Item A5)

1. The Chairman welcomed Andrew Ireland and Mark Lobban to the meeting in their new roles as Corporate Director of Families and Social Care and Director of Strategic Commissioning, respectively.

Mrs Valerie Dagger

2. Members asked that their best wishes be sent to Mrs Dagger for a speedy recovery following a recent fall. Miss Grayell undertook to write on behalf of the Committee.

53. Oral Updates by Cabinet Member, Corporate Director of Families and Social Care and Director of Public Health

(Item A6)

1. Mr Gibbens gave an oral update on the following:-

- *Welcome to Andrew Ireland, New Corporate Director of Families and Social Care*

- *District Public Health Visits are underway*
 - *Launch of Live it Well Website took place on Mental Health Day 10 October*
 - *Attended meeting with Paul Burstow MP at the National Children's and Adult Services Conference on 20 October*
 - *Welfare Reform Informal Members Working Group and Department of Work and Pensions Visit to Ashford Gateway on 31 October*
 - *House of Commons Select Committee Call for Evidence Joint Response – a response had been made on behalf of, and in the name of, SECASC (South East Councils for Adult Social Care). Mr Gibbens undertook to circulate a copy of this response to POSC Members upon request.*
 - *Visit to Dartford and Gravesham with Dartford and Gravesham Members to be arranged for 1 December*
 - *Attending Public Health Practitioner Portfolio Assessment of National Pilot Schemes Event on 7 December in London*
2. Mr Ireland gave an oral update on the following:-
- *During his first month in post he will make a series of visits to District offices to meet staff and see the up to date picture*
 - *Initial aims – to improve and increase joint working, take forward existing strategies and build links*
 - *The Interim Director, Malcolm Newsam, will stay until the end of November to allow a handover period and will take a lead in operational issues for both Adults' and Children's Services*
3. On behalf of the Director of Public Health, Mr Scott-Clark gave an oral update on the five key Public Health papers expected in the near future:-
- *Operating Model for Public Health England (due in November, but was still awaited in early December when these minutes were finalised)*
 - *Public Health Outcomes Framework (due in November, but was still awaited in early December when these minutes were finalised)*
 - *Public Health Human Resources Concordat published by the NHS and Local Government Association (workforce issues relating to the transfer of Public Health to Local Authorities) (published 18 November)*
 - *NHS Operating Framework (published 24 November) and Shadow Budget allocation for Health Improvement (due before Christmas)*
 - *Public Health Workforce Consultation Paper (due in December, but now expected in January)*

Mr Gibbens undertook to share this list with POSC Members and collate views from them on the respective consultation papers.

54. Kent and Medway Safeguarding Vulnerable Adults Annual Report, April 2009 - March 2010 and April 2010 - March 2011
(Item C1)

Mr N Sherlock, Head of Adult Safeguarding, was in attendance for this item.

1. Mr Sherlock introduced the report and emphasised that the Kent and Medway Safeguarding Vulnerable Adults Board is a multi-agency body. Mr Sherlock, Mr

Gibbens, Mr Ireland and Mrs Tidmarsh responded to comments and questions from Members, and the following points were highlighted:-

- a) the Board is not yet operating on a fully-statutory basis, and hence there is no clear detailed national guidance on the constitution or membership of it. The structure and membership of the Board are both due for review shortly, to ensure that it is best able to fulfil its role in the future. For example, KMPT is part of the network but not of the Board's executive;
- b) Members expressed concern that safeguarding issues arising at a hospital in the Dartford and Gravesham area had not been mentioned in the report. The timescale of preparing the report for POSC and the method of gathering information had meant that the Care Quality Commission's recent findings had not been included in it, but they will be set out in full in next year's annual report. The issue had come to light from an inspection and had not arisen as a safeguarding incident;
- c) Mr Gibbens reassured Members that, as the lead Member for adult safeguarding in Kent, he took his responsibilities very seriously. He reminded Members that the KCC's legal role in respect of adult safeguarding was different to its role in respect of children's safeguarding. He explained that he holds a quarterly meeting with Mr Sherlock at which safeguarding issues are examined in detail. He emphasised that the reporting lines for incidents are robust and independent;
- d) figures in the report show a decrease in the financial contribution made to the Board by the KCC, but this is because the provision of training would in future be provided by the KCC. No specific targets for training in adult safeguarding are currently set, but the KCC sets its own staff training targets as part of Bold Steps for Kent; and
- e) some partners on the Board had reduced their financial contribution due to their constrained budget situation, and as the Board moves to a more statutory footing and financial input is more formalised, it is possible that more bodies will review their financial commitment.

2. RESOLVED that the information set out in the report and in response to comments and questions be noted, with thanks.

55. Presentation on 'What is Public Health?'

(Item D1)

1. Mr Scott-Clark presented a series of slides which set out the history of and background to public health as a profession, and the new responsibilities for public health which will transfer to the KCC. He responded to comments and questions from Members, and the following points were highlighted:-

- a) public health had previously been a responsibility of the County Council in the 1970s, had moved away and is now returning; and

- b) public health regulation is a mixture of statutory and voluntary; Public Health consultants must be on the General Medical Council Specialist register or on the UK Public Health register. There is currently no professional register for health promotion specialists. A review of the arrangements for professional regulation was undertaken in 2010.
2. RESOLVED that the information set out in the presentation and given in response to comments and questions be noted, with thanks.

56. Update of Public Health Expenditure
(Item D2)

1. Mr Scott-Clark introduced the report and responded to comments and questions from Members. The following points were highlighted:-
 - a) strategic and local funding priorities need to be considered together to get a picture of need, and Locality Boards have a role to play in achieving this; and
 - b) the report contains figures for investment in weight management services across West Kent districts. In East Kent, service commissioning is accounted for differently, although the same outcome is achieved.
2. RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks.

57. 'Live it Well' - the Kent and Medway Mental Health Strategy for 2010 to 2015 - Update
(Item E1)

Mr P Absolon, Social Care Commissioner for Mental Health, was in attendance for this item.

1. Mr Absolon introduced the report and explained that this is the first year of the five-year Live It Well Strategy. Some good outcomes had so far been achieved, and the Strategy is a good example of successful joint working.
2. RESOLVED that the information set out in the report be noted, with thanks.

58. Update on the Kent Health and Wellbeing Board
(Item E2)

1. Mr Scott-Clark introduced the report and responded to comments and questions from Members.
2. The shadow Health and Wellbeing Board includes three representatives from District or Borough Councils, selected by the Kent Forum. These representatives are from Tunbridge Wells, Tonbridge and Malling and Swale. Concern was expressed that East Kent is not represented, but it was explained that this is not an issue over which the KCC has any influence.

3. RESOLVED that the information set out in the report be noted, with thanks.

59. Select Committee: Dementia - a New Stage in Life

(Item E3)

Mrs T Dean was present for this item as the Chairman of the Dementia Select Committee.

1. Mrs Dean introduced the final draft of the Executive Summary of the Select Committee report and explained that it was being presented to the POSC for its support prior to being considered by the Cabinet and full Council in December.

2. Members welcomed the range, scope and clarity of the Select Committee's report. They commended the way in which it highlighted long-standing issues around the diagnosis and understanding of Dementia. In particular, they commented on the importance of early diagnosis, the role played by memory cafes and reminiscence sessions, and what Members can do to support these.

3. Mrs Dean placed on record her thanks to the Research Officer for her work and commitment, which had resulted in an immensely good quality piece of work. Mrs Tidmarsh and Mr Gibbens added that the report's recommendations gave the Directorate an ideal opportunity to review and refresh its action plans and both expressed their eagerness to begin work on taking forward the recommendations.

4. RESOLVED that:-

- a) the final draft of the Executive Summary of the Select Committee's report 'Dementia – A New Stage in Life' be welcomed and supported onwards to the Cabinet and County Council; and
- b) the Select Committee, Researcher and officer team and participants be thanked for their excellent work.

60. Adult Social Care Budget Forecast and Savings Report 2011/12 and Debt Position September 2011

(Item E4)

Miss M Goldsmith, Families and Social Care Finance Business Partner, was in attendance for this and the following item.

1. Miss Goldsmith introduced the report and she and Mrs Tidmarsh responded to comments and questions from Members. The following points were highlighted:-

- a) vacancies always exist to a greater or lesser extent across the Directorate, and are managed in a way which minimises the impact upon front-line service provision. Adult Social Care are managing but not currently holding vacancies, and are currently recruiting; and
- b) Miss Goldsmith and Mrs Tidmarsh undertook to supply more detail about the management of Adult Social Care vacancies outside the meeting.

2. RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks.

61. Revenue Budget 2012/13 and Medium Term Financial Plan 2012/13 to 2014/15

(Item E5)

1. Miss Goldsmith introduced the report and responded to comments and questions from Members. The following points were highlighted:-

- a) a one-year government grant for 2012/13 is to be given to Councils which continue to freeze Council Tax, and Members expressed concern that when this finishes there will be a substantial shortfall in funding which will need to be addressed;
- b) Mr Ireland added that he would be working closely with finance colleagues to examine the detail of the Adult Social Care budget, and Miss Goldsmith undertook to respond to questions of detail outside the meeting;
- c) figures which had previously been produced to illustrate a £10 million saving in the Adult Social Care budget had been prepared in response to an exercise which sought to identify the likely impact of making hypothetical savings of varying severity. The Directorate was not being asked to make this saving; and
- d) an Informal Member Group had met through the summer and autumn and had reported back to the POSC that it did not feel prepared or able to identify potential savings without having further information.

3. RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks. No potential savings were identified.

62. Families and Social Care In-House Services - Adults

(Item E6)

1. Mr Lobban introduced the report and responded to comments and questions from Members. The following points were highlighted:-

- a) Adult Social Care (ASC) in-house services had all been rated as 'good' or 'excellent', and good quality staff training is a vital part of achieving these ratings; and
- b) the Directorate's move towards being a commissioner rather than a direct provider must not be allowed to detract from the primary importance of delivering services to vulnerable people, and this should be guarded against.

2. RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks.

63. Outcome of Formal Consultation on a New Service Model for Learning Disability Day Services in the Thanet District
(Item E7)

Ms P Watson, Commissioning Manager for Learning Disability, was in attendance for this item, with Ms Southern.

1. Ms Southern introduced the report and responded to comments and questions from Members. The following points were highlighted:-

- a) the same consultation process had been followed and the same service model used as for recent similar reviews in Maidstone and Ashford. A range of engagement methods had been used, and feedback had shown that the approach taken had been appreciated by consultees;
- b) a bid from East Kent Mencap, outlined in the report, had been received on the very last day of consultation. Ms Southern confirmed that, although it had been proposed that this bid should not be pursued at this time, further work and negotiation around the bid has not been ruled out. As the bid had arrived very late in the process, she had not had the opportunity to explore it as thoroughly as she would need to under the KCC's procurement rules;
- c) as a Thanet Member, Mr M J Jarvis said he had attended consultation meetings but had not been aware of the Mencap bid. He supported further exploration of the bid as no other alternative proposal had come forward. The importance of early local Member involvement was highlighted and Mr Gibbens undertook to ensure that all local Members were fully involved before he takes the decision;
- d) some service users who are currently eligible for free transport will continue to receive transport, although some may incur a charge, depending on the overall package of services they receive and which of these other services are charged;
- e) direct payments offer service users a choice of how they wish to access services, and it is not possible to guarantee that any given proportion of users will continue to choose KCC services. Where take-up of these services declines, and they become less cost-effective to deliver to a smaller audience, the KCC will still need to continue to offer services to those who have chosen them and depend on them; and
- f) as in Ashford and Maidstone, the new service delivery model in Thanet will be subject to a ongoing evaluation process, and progress reports will be made after six months and twelve months.

2. Members expressed concern that the decision which the Cabinet Member was being asked to take precluded any further work on and negotiation of the East Kent Mencap bid. Mr S J G Koowaree suggested an additional recommendation to specify continued negotiation with East Kent Mencap. After discussion, this was not seconded or pursued as Mr Gibbens and Mr Ireland confirmed that they were confident that the report's current recommendations, and the decision which the

Cabinet Member will shortly be asked to take, did not preclude any further discussion or investigation of the bid put forward by East Kent Mencap. Members welcomed this reassurance.

3. RESOLVED that the information set out in the report, and the decision which the Cabinet Member will shortly be asked to take, be noted.

64. Update on Select Committee Work
(Item G1)

RESOLVED that the content of the report be noted, with thanks.

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **BUDGET 2012/13 AND MEDIUM TERM FINANCIAL PLAN 2012/15**

Classification: Unrestricted

Summary: The purpose of this report is to consult the Committee on the budget proposals for the Adult Social Care and Public Health Portfolio(s), with reference to the draft KCC budget launched on 20 December 2011.

Members are invited to comment on the key issues on the proposed budget changes for the services provided by the Families and Social Care Directorate.

Introduction

1. (1) The Chancellor of the Exchequer made his Autumn Budget Statement to the House of Commons on 29 November 2011. This coincided with the latest economic forecasts from the Office for Budget Responsibility (OBR) which predicted that recovery from the recession would take longer than previously forecast and economic growth projections for the remainder of 2011 and throughout 2012 would be substantially less than earlier forecasts. The Government's deficit recovery strategy relies on steady and sustainable economic growth in order that tax revenues recover from the effects of recession and remain buoyant in the future. In spite of the lower growth predictions the Chancellor has stuck with the spending plans outlined in the 2010 Spending Review (SR2010).

(2) The provisional Local Government Finance Settlement for 2012/13 was announced on 8 December 2011. This set out provisional grants for 2012/13 from the Department for Communities and Local Government (DCLG). This includes the vast majority of un-ringfenced grants. The grants from DCLG were in line with the provisional figures included in the 2011/12 settlement but no provisional amounts have been announced for the following years.

(3) Following these announcements KCC launched its draft 2012/13 Budget and 2012/15 Medium Term Financial Plan (MTFP) for consultation on 20 December. The documents include much more information about the national economic context and grant settlement, as well the Council's proposals. Members are asked to review these documents and bring them to the committee meeting where the proposals affecting the Adult Social Care and Public Health portfolio will be considered.

(4) For 2012/13 the draft budget proposes freezing Council Tax at the same level as 2011/12 i.e. £1,047.48 for a band D property and taking up the one-off grant offered by government. Taking up this grant means that £14.4m of additional savings/income will have to be found in 2013/14 to offset the loss of grant. The Council Tax Freeze grant is factored into our calculations on the overall net loss of grant in 2012/13 and 2013/14.

(5) The grant settlements for other Government departments had not been announced in time for the budget launch. Since these are largely ring fenced and its KCC policy to adapt spending in line with grant settlements these will not unduly affect the proposed budget.

Revenue Budget Proposals

2. (1) The draft budget book includes a portfolio summary, an updated A to Z of services and for the first time a detailed variation statement for each line in the A to Z showing all the changes between 2011/12 and 2012/13. The introduction of an A to Z of services rather than a portfolio by portfolio presentation of the budget was largely welcomed last year. The detailed variation statement is further step towards greater transparency of the underlying assumptions behind the proposed budget. We recognise that removing the portfolio by portfolio presentation makes it more difficult for Policy Overview and Scrutiny Committees to scrutinise the proposals for individual portfolios and thus for ease of reference the A to Z entries for the Adult Social Care and Public Health portfolio are included as Appendix 1 to this report.

(2) The MTFP sets out the overall assumptions about the likely resources available over the next 3 years. It also sets out the forecast additional spending demands and the savings/income which would be necessary to achieve a balanced budget each year. The savings have been expressed as target amounts for efficiencies and service reforms under a number of themes. The MTFP has been redesigned to present a clearer overall picture over the three year period rather than portfolio by portfolio.

(3) The MTFP includes a portfolio by portfolio analysis of the main changes within the proposed 2012/13 budget. This is presented in the same format as the previous multi year presentation. Experience has shown that although we produced a 3 year plan by portfolio nearly all of the issues relate to the first year and the detail for years 2 and 3 are largely aspirations and change significantly when the budget for these years comes to be approved at a later date. The one year presentation by portfolio should help Policy Overview and Scrutiny Committee members to focus on portfolio priorities for the coming year.

(4) As in 2011/12 the detailed budgets for individual service units and budget managers will be produced after County Council has agreed the draft budget in A to Z format. This detailed manager analysis will include staffing information for individual units.

(5) Copies of the draft Budget Book and MTFP have been distributed to all Members (on 16 December). You are asked to ensure you bring those to this meeting.

Capital Budget

3. (1) The starting point for the capital programme is the existing published capital programme for 2011/14. We have revised the presentation of the capital programme for individual schemes to shift the focus away from planned spending year by year and more towards the totality of spend and how this is financed. This will enable debate to focus on the merit of schemes, their affordability and overall timeliness rather than the detail of re-phasing individual amounts between years.

(2) The proposed programme for the Adult Social Care and Public Health portfolio for 2012/15 is set out page 10 of the Draft Budget Book

Recommendation

4. (1) Members are asked to NOTE and COMMENT ON the revenue and capital budget proposals for the Adult Social Care and Public Health portfolio.

Background documents:

- Autumn Budget Statement; Cabinet, 5 December 2011
- Draft Budget Book 2012/13 and Medium Term Financial Plan 2012/15 (launched 20 December 2011)
- Previous Budget Monitoring and Planning Reports to the Adult Social Care and Public Health Policy Overview and Scrutiny Committee

Officer contact:

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Section 5 - A to Z Service Analysis (ASC&PH portfolio)

Appendix 1

WHAT IS THE MONEY SPENT ON?

2011/12 Approved	Portfolio	Service	2012/13 Proposed							Affordable Activity
Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	
		Adults and Older People								
		<i>Direct Payments</i>								
9,542	ASC&PH	Learning Disability	0	11,465	11,465	-547	10,918	0	10,918	Approximately 1000 clients are expected to be receiving an on-going direct payment. These people have been assessed as being eligible for social care support, but have chosen to arrange and pay for their own care and support services instead of receiving them directly from the local authority. There will also be a number of one-off direct payments made during the year for such things as items of equipment and respite care
732	ASC&PH	Mental Health	0	988	988	0	988	0	988	Approximately 200 clients are expected to be receiving an on-going direct payment; there will also be a number of one-off direct payments made during the year.
5,649	ASC&PH	Older People	0	6,945	6,945	-787	6,158	0	6,158	Around 1000 clients will be receiving an on-going direct payment; there will also be a number of one-off direct payments made during the year.
7,895	ASC&PH	Physical Disability	0	9,479	9,479	-374	9,105	0	9,105	Around 1000 clients are expected to be receiving an on-going direct payment ; there will also be a number of one-off direct payments made during the year.
		<i>Domiciliary Care</i>								
5,972	ASC&PH	Learning Disability	2,728	3,587	6,315	-1,187	5,128	0	5,128	Domiciliary care provided by the independent sector supporting approximately 420 people to live at home. In addition this service provides: support to 120 people through the independent living scheme and other domiciliary support
802	ASC&PH	Mental Health	0	523	523	-80	443	0	443	Services provided through the independent sector supporting people to live at home

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Section 5 - A to Z Service Analysis (ASC&PH portfolio)

Appendix 1

WHAT IS THE MONEY SPENT ON?

2011/12 Approved	Portfolio	Service	2012/13 Proposed							Affordable Activity
Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	
36,114	ASC&PH	Older People	6,111	37,256	43,367	-12,033	31,334	0	31,334	Domiciliary care provided by the independent sector supporting nearly 5,000 people to live at home. In addition this service provides: - the Kent Enablement at Home Service which provides intensive short term support/enablement to people to allow them to regain or extend their independent living skills; and a number of small contracts for services primarily with Health, including the night sitting service, recuperative care and rapid response.
7,223	ASC&PH	Physical Disability	268	7,221	7,489	-576	6,913	0	6,913	Domiciliary care provided by the independent sector supporting approximately 950 people to live at home. This service also provides other domiciliary support (KCC and Independent Living Scheme).
Page 14		<i>Nursing and Residential Care</i>								
52,035	ASC&PH	Learning Disability	1,874	73,397	75,271	-6,459	68,812	0	68,812	620 clients are provided services through the independent sector. In addition, this service provides: permanent residential care for preserved rights clients through the independent sector and 88 respite beds across various KCC
5,904	ASC&PH	Mental Health	0	6,875	6,875	-875	6,000	0	6,000	10,300 weeks of residential care provided through the independent sector. This service also provides approximately 3,000 weeks of permanent residential care for preserved rights clients through the independent sector.
23,494	ASC&PH	Older People - Nursing	0	44,439	44,439	-22,674	21,765	0	21,765	Around 1,500 clients provided this service through the independent sector. This service administers the payment of the health element of the nursing cost and reclaims this from PCT's
51,712	ASC&PH	Older People - Residential	13,174	71,675	84,849	-36,494	48,355	0	48,355	Approximately 2,900 clients on average provided through the independent sector. In addition, this service provides: permanent residential care for preserved rights clients provided through the independent sector. In-house this provides 201 residential care beds and 60 nursing care beds.

Section 5 - A to Z Service Analysis (ASC&PH portfolio)

Appendix 1

WHAT IS THE MONEY SPENT ON?

2011/12 Approved	Portfolio	Service	2012/13 Proposed							Affordable Activity
Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	
10,625	ASC&PH	Physical Disability	0	13,692	13,692	-1,969	11,723	0	11,723	Approximately 260 clients provided this service through the independent sector.
		Supported Accommodation								
12,194	ASC&PH	Learning Disability	456	32,331	32,787	-3,694	29,093	0	29,093	Services provided through the independent sector for approximately 620 people in supported accommodation/supported living.
955	ASC&PH	Physical Disability/Mental Health	0	2,539	2,539	-274	2,265	0	2,265	Services provided through the independent sector in respect of individuals in supported living and supported accommodation
		Other Services for Adults and Older People								
14,624	ASC&PH	Contributions to Voluntary Organisations	0	16,044	16,044	-902	15,142	0	15,142	Payments to voluntary organisations for a range of preventative services supporting approximately 6,000 people.
		Day Care								
12,388	ASC&PH	Learning Disability	6,904	6,061	12,965	-503	12,462	0	12,462	Day care/day services provided both in the independent sector and in-house
4,291	ASC&PH	Older People	1,755	1,372	3,127	-195	2,932	0	2,932	Day care/day services provided both in the independent sector and in-house
1,657	ASC&PH	Physical Disability / Mental Health	0	1,552	1,552	-38	1,514	0	1,514	Day care/day services provided both in the independent sector and in-house
6,082	ASC&PH	Other Adult Services	1,148	16,761	17,909	-23,780	-5,871	0	-5,871	A range of other services including: - approximately 240,000 home delivered hot meals; Occupational Therapy & Sensory Disability services working in partnership with Health, Hi Kent and Kent Association for the Blind to provide approximately 56,000 items of equipment. Community outreach support to clients with mental health problems; providing support for people with a disability to fund and keep work; collaborating with health on the delivery of Telehealth and Telecare services.
0	ASC&PH	Safeguarding	461	340	801	-236	565	0	565	A multi agency partnership/framework to ensure a coherent policy for the protection of vulnerable adults
		Community Services								

Section 5 - A to Z Service Analysis (ASC&PH portfolio)

Appendix 1

WHAT IS THE MONEY SPENT ON?

2011/12 Approved	Portfolio	Service	2012/13 Proposed							Affordable Activity
Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	
93	ASC&PH	Public Health (incl. Local Involvement Network)	64	553	617	-117	500	0	500	Health Promotion and the 'Mobile House' project which delivers discreet lifestyle messages to promote behavioural change. Funding for the Kent LINK and payment to an independent company whose role it is to help the work of the Kent LINK in improving health and social care services
269,983		Total Direct Services to the Public	34,943	365,095	400,038	-113,794	286,244	0	286,244	
Page 16		<u>Assessment Services</u>								
38,509	ASC&PH	Adult's Social Care Staffing	23,706	15,771	39,477	-1,981	37,496	0	37,496	Social care staffing providing assessment of community care needs undertaken by Case Managers and Mental Health Social Workers
38,509		Total Intermediate Services	23,706	15,771	39,477	-1,981	37,496	0	37,496	
		<u>Management, Support Services and Overheads</u>								
8,631	ASC&PH	Directorate Management & Support - Families and Social Care (FSC)	1,141	7,415	8,556	-485	8,071		8,071	
311	ASC&PH	Directorate Management & Support - Business Strategy & Support (BSS)	292	78	370		370		370	
8,942		Total Management, Support Services and Overheads	1,433	7,493	8,926	-485	8,441	0	8,441	Overheads no longer sit with the Directorates so 2012/13 costs are not directly comparable with 2011/12. They have been stripped out, slimmed down and transferred to the centre.
317,434		TOTAL	60,082	388,359	448,441	-116,260	332,181	0	332,181	

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee –
10 January 2012

Subject: **KCC Health Inequalities Strategy Update**

Classification: (Unrestricted)

Summary: The Health Inequalities Action Plan is currently ***working progress***, in preparation for County Council in March 2012. It is being driven by the 6 Marmot objectives recommended to help reduce inequalities along with the most prominent joint priorities identified within the Joint Strategic Needs Assessment. A Core Health Inequalities Group has provided District representation to ensure effective local delivery. The Actions identify key areas partners consider major changes need to be made to reduce the gap of health inequalities. These will be measured against challenging indicators that will demonstrate a reduction of inequalities, not just increased uptake of activities within the locality. The monitoring and progress of the Health Inequalities Action Plan will be overseen by the Kent Health Inequalities Group which is closely aligned to all three Kent Ambition Boards, giving particularly support to Ambition Board 2, Tackling Disadvantage

FOR INFORMATION

1. Background

1.1 In September 2011 the Cabinet Member for Public Health announced that there will be a new Kent Health Inequalities Action Plan presented to County Council in March 2012. The purpose of the Plan is to support the existing Kent Health Inequalities Strategy in developing clear actions and priorities that Public Health and partners can progress to demonstrate a reduction in health inequalities.

1.2 The current transition to transfer Public Health responsibility into Local Authorities by 2013 is a timely opportunity for Public, Private, Voluntary sectors and social enterprises to work collaboratively and join forces to reach a variety of aspects of people's lives in order to make a difference.

1.3 The aim of Health Inequalities Action Plan is to be active and owned by all partners. Contributions have been made by Public Health Consultants, Specialists and Local Government Officers.

2. The Action Plan

2.1 The Action Plan is defined by the 6 Marmot Policy themes to promote the 'life-course' approach and encourages the inclusion of wider social determinants such as Housing, Transport, Education and Employment.

2.2 Under each Life-course theme, a set of priorities have been identified from the JSNA. The Actions listed below each priority have been offered as examples of what is being done to support them. **Only actions that demonstrate the effective targeting and outcomes for health inequalities have been included.** Conditions that are not fundamentally entrenched in inequalities (such as dementia for example) and are prevalent across all social groups have not been prioritised in this plan. Each chapter also includes a summary of the local performance for the priority headings taken from the regional Red, Amber, Green rating profiles. Using the traffic light system, each locality can identify their priority against local need.

2.3 Further detail on the actions listed are given in the Aspirations table. This includes measurable indicators to ensure they can be measured in terms of health inequalities. The imminent Public Health Outcome Framework will shape further changes, but partners are responsible for agreeing the baseline and target level for each individual action identified. The 'What Good Will Look Like in 2015' column is currently work in progress and requiring most refinement as commitment to each of the goals are being agreed by relevant lead teams and agencies.

3. Developing the Action Plan

3.1 The current transition to transfer Public Health responsibility into Local Authorities by 2013 is a timely opportunity for Public , Private, Voluntary sectors and social enterprises to work collaboratively and join forces to reach a variety of aspects of people's lives in order to make a difference. Further work is currently being undertaken to consolidate the framework of the Action Plan into the roles and priorities of the health and Wellbeing Boards and Clinical Commissioning Consortia .

3.2 **3.2.1** Together, we can be smarter in the effective targeting of inequalities and utilising resources to support the Action Plan. Additional ways we can do this should be mainstreamed in policy and planning procedures:

3.2.2. Accessing Intelligence held by the Kent Public Health Observatory – *to target resources and need and to ensure that activities are being accessed by those who most need it*

3.2.3. Mosaic profiling to gain insight and intelligence in the understanding of attitudes and behaviours that are most likely to attract the most vulnerable groups

3.2.4. Demonstrating evidence of customer/public engagement to empower and encourage local ownership and sustainability of actions and activities

3.2.5 Adopt as standard, targeted screening tools modelled by the Mental Wellbeing Impact Assessment which includes fundamental elements of Health Inequalities. Further work is being developed to mainstream a tailored Kent Screening Model with Inshuk Training commissioned by the Mental Health Development Services Unit.

3.2.6 Adopt the Health Inequalities National Support Team Associates (HINST) 'Christmas Tree' model to assure all elements of policy and design are aligned to insight and delivery.

3.2.7 Agree that Initiatives and actions should be scaled up and delivered systematically where appropriate accompanied by robust evidenced outcomes. However, we must also be innovative which sometimes incurs risk.

- 3.3** This Health Inequalities Action Plan will be active, promoted and owned by us all. Contributions have been made by Public Health Consultants, Specialists and Local Government Officers and District Authorities, with additional representation from the voluntary sector.
- 3.4** The current status of the Health Inequalities Action Plan is ***work in progress*** until the quantifiable target outcomes have been refined and agreed.
- 3.5** The monitoring and progress of the Health Inequalities Action Plan will be overseen by the Kent Health Inequalities Group which will provide regular updates to Public Health DMT and to POSC as and when required.
- 3.6** The Action Plan is also to be closely aligned to the priorities of all three Kent Ambition Boards, giving particularly support to Ambition Board 2, Tackling Disadvantage

Recommendations

- Policy Overview and Scrutiny Committee are asked to:
- i) note the contents of this paper.
 - ii) Support in principle, the Kent Health Inequalities Action Plan.
 - iii) Agree to the course of action identified in 3.21-3.27
-

Contact Officer:

Deborah Smith
Policy Manager, Kent Public Health Department
Tel: 01622 696176

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**Kent's Health Inequality Action Plan
2012 - 2015**
The Six Stages of the Life Course

INTRODUCTION

Foreword– Meradin Peachey, Director for Public Health-to be added

Foreword – Graham Gibbens, Cabinet Member for Adult Social Care and Public Health- to be added

We are pleased to be working towards Marmot’s life-course approach adopted by KCC Cabinet to reach the touch points of people’s lives when, where and in a way they most need them.

Background

The Kent County Council Health Inequalities Strategy (2008) sets out the direction and approach to reducing health inequalities in Kent.

Since its publication, the Marmot Policy Objectives recommended to significantly reduce health inequalities have been endorsed by the County Council and the release of the Public Health White Paper in 2011 has meant that by 2013, responsibility for many areas of Public Health will be transferred from Primary Care Trusts to the Local Authority. In Kent, an early shadow arrangement has already commenced, enabling a stronger partnership and collaborative commitment to reducing inequalities and greater opportunities for addressing the wider determinants of health and individual lifestyles that determine fundamental outcomes for people.

The Kent Health Inequalities Action Plan refreshes the commitment and strengthens the contributions made by all key stakeholders. It has a wider and more collective ownership and commitment to health inequalities, so that we can all work together to really make a difference.

This will require a focused, targeted approach to inequalities and strong partnerships with the Kent Community to gain insight into attitudes and behaviours raise aspirations and increase opportunities for people and communities to maximise the potential for healthier, stronger lives. We want all residents in Kent to live longer, healthier lives and we want to improve the lives of the poorest fastest.

Over £21bn of the UK’s annual health budget has been spent on reducing health inequalities and yet the gap between the richest and poorest in society has increased rather than reduced. Under the new Local Authority responsibilities there is an opportunity to ensure that an appropriate proportion of health inequalities funding can now be committed to reducing the cause and not just tackling the consequences of inequalities.

This Action Plan, driven by the Joint Strategic Needs Assessment and Marmot’s Life-course objectives provides a clear, focused commitment to how and by when we will see outcomes to reduce to the inequalities gap.

Main causes of deaths in England –Wales 2001 (ONS)
The greatest (and broadest) measure of health inequalities is ‘life expectancy at birth’. Against this

measure, the UK is currently positioned 28th in the world with main causes of premature death:

1. Circulatory Disease 219,087
2. Cancers 136,234
3. All other causes 105,201
4. Respiratory 67,468

Access to early diagnosis and treatment pathways are essential to effectively treat people with these conditions, but it is more efficient and beneficial to prevent the conditions in the first place. This requires targeting health promotion and interventions, in ways that best reach those more at risk of conditions, most of which are prevalent in areas of deprivation and low socio-economic groups. By developing the Mental Health and Wellbeing Impact Assessment, we will produce a screening tool that can demonstrate that the right people are accessing interventions. Together, Public, Private, Voluntary sectors can contribute to reducing the risk and prevalence of these health conditions that result in premature mortality disproportionately among the more deprived groups.

Developing the Action Plan

This Action Plan is centred around needs and priorities identified in Kent's Joint Strategic Needs Assessment and which in turn, informs the Strategies, Business Plans and Local Delivery Frameworks across the Local Authority. As the responsibility for Public Health transfers into Local Authorities by 2013 it is a timely opportunity for Public, Private, Voluntary sectors and social enterprises to work collaboratively and join forces to reach a variety of aspects of people's lives in order to make a difference.

Together, we can be smarter in the effective targeting of inequalities; intelligence held by the Kent Public Health Observatory and Mosaic; re-modeling existing screening tools such as the Mental Wellbeing Impact Assessment and listening to the public voice should be routinely applied and mainstreamed throughout the Public Sector. These will be essential tasks to supporting the Action Plan.

The Health Inequalities Action Plan has been composed under the 6 Marmot Policy themes endorsed by Kent County Council. This promotes the 'life-course' approach and encourages the inclusion of wider social determinants such as Housing, Transport, Education and Employment.

Under each Life-course theme, a set of priorities have been identified from the JSNA and partners have agreed actions that support them. Only actions that demonstrate the effective targeting of reducing inequalities for most vulnerable groups have been included. Health promotion issues that are widespread in all social and local groups and not endemic in health inequalities (such as dementia) have not been included. Each chapter also highlights the significance to Districts who have a role in prioritising health inequalities in their locality.

Lastly but importantly, all actions include measurable indicators to ensure that progress can be monitored against health inequalities. All stakeholders are committed to aspiring to achieve a measure of good practice under the 'What Good Will Look Like in 2015' section. This is where the scaling up and systematic delivery of effective programmes with robust outcomes will come into effect and where challenges, risks and innovation will need to be applied.

1:
Give every
Child the best
start in life

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Improving health in the early years of life contributes considerably to better health outcomes in later life, with reduced levels of diabetes, coronary heart disease and hypertension, all of which have a significant impact on the NHS as well as wider society, children and their families.

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. (Marmot Review 2010)

Objective 1A: Give every child the best start in life (Conception-9 months)

Priorities

1A: Support good health and wellbeing in pregnancy and the newborn

1a.1 Help increase the number of healthy births

1a.2 Support infant feeding by achieving Unicef's Baby Friendly accreditation

Actions

1a.1.1 Strengthen midwifery and stop smoking resources to reduce smoking in pregnancy

1a.1.2 Strengthen buddy role through Midwifery

1a.1.3 Campaign to promote good health in pregnancy

1a.1.4 Ensure teenage mothers have additional support

1a.1.5 Supporting pregnant women who are experiencing domestic violence

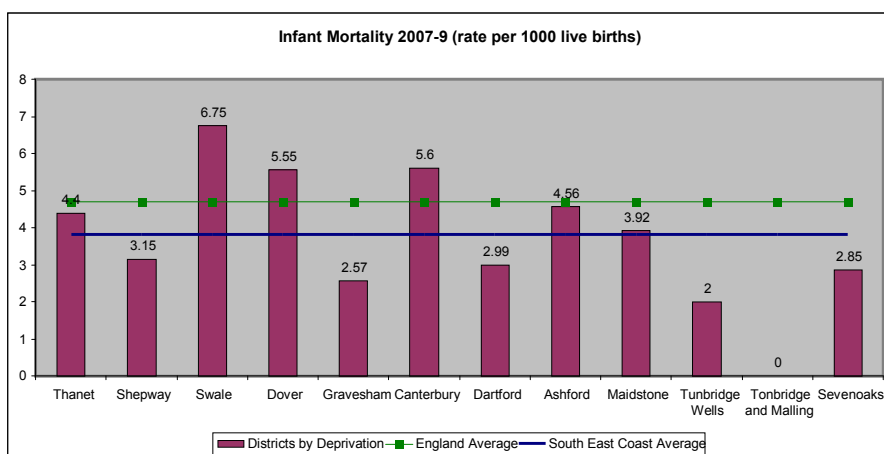
1a.2.1 Increase breast-feeding initiation rates and prevalence at 6-8 weeks by putting the infant feeding action plan in place

1a.2.2 Develop a needs assessment for breastfeeding to support targeting and commissioning of services

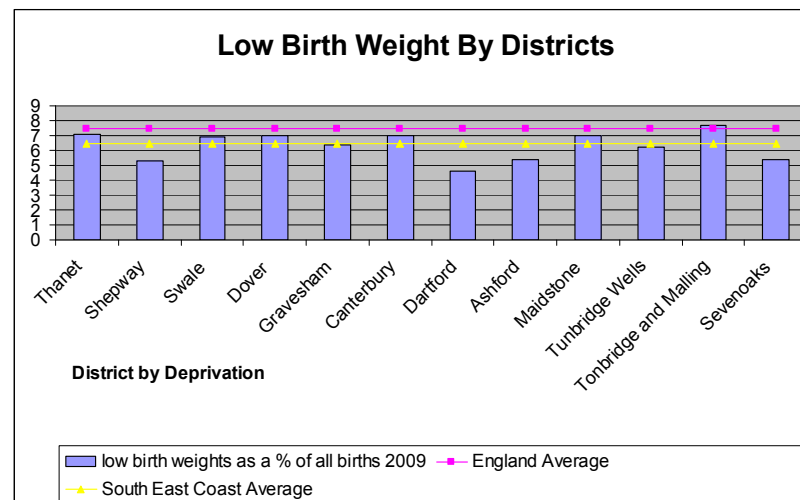
1A. Give every child the best start in life

Priority 1a.1 Help increase number of healthy births

- The overall rate for infant mortality for Kent has been consistently lower than the England and Wales rate. However there are differences in infant mortality rates which could point to a health inequality based on socio-economic circumstances. There are a higher number of infant deaths in East Kent and latest data indicates that Swale far exceeds the England average with Canterbury and Dover above the England average. There were NO infant deaths reported in Tonbridge and Malling. It should be noted that the incidence is low and the overall trend can be distorted by specific cases.



Chimat 2011



- Low birth weight has serious consequences for health in later life. Increased viability and survival of very pre-term infants due to advances in medical technology will account for some of the very low birth rate weights.
- Smoking in pregnancy is known to affect both birth weight and incidence of infant mortality and continues to impact on the health of a child.
- Domestic violence is more likely to occur to women in their reproductive years, from lower socio-economic areas and often increases during pregnancy.
- A particularly vulnerable group is teenage mothers who are much more likely to be smoking both at booking and at delivery posing considerable risk to both themselves and their babies. They are also highly likely to access services late, potentially further compromising their care. Teenage mothers had a statistically significant higher rate of stillbirths. Postnatally they had much lower rates of breastfeeding at both birth at 6-8 weeks.

1a.2 Support infant feeding by achieving Unicef's Baby Friendly accreditation

Breastfeeding makes an important contribution to the health of mothers and infants. The Government has committed to increase support for breastfeeding as part of its strategy to reduce health inequalities and has set a target to increase breastfeeding initiation rates by 2% per year, focusing particularly on women from disadvantaged groups. In Kent averages in breastfeeding at birth mask significant disparity between Hospital Trusts. For example from April- June 2011 65% of new mothers breastfed at the Darent Valley Hospital, 78% did so at Maidstone and Tunbridge Wells.

Local Profile

District comparison to the Strategic Health Authority average. All districts are performing poorly against SHA average for breastfeeding initiation but data has been aggregated across the 12 Districts so there is some masking of performance. A needs assessment exploring breastfeeding should address this issue.

	Breast Feeding Initiation	Low Birth weight	Infant Mortality	Smoking in pregnancy
Ashford	X	-	-	X
Canterbury	X	X	-	X
Dartford	X	X	-	-
Dover	X	-	-	X
Gravesham	X	-	-	-
Maidstone	X	X	-	-
Sevenoaks	X	-	-	-
Shepway	X	-	-	X
Swale	X	X	X	X
Thanet	X	X	-	X
Tonbridge & Malling	X	X	-	-
Tunbridge Wells	X	√	√	-

X	Significantly worse than SHA average
-	Not significantly different from SHA average
√	Significantly better than SHA average

The Aspirations

Action	What good will look like in 2015	Aspirational Targets
1a.1 Increase Numbers of Healthy Births		
All women are supported throughout their pregnancy, know how and when to access services and can easily find support in their community. They have access to help and information about avoidable risks and lifestyle choices to keep their baby healthy. Women in deprived areas or in at risk groups receive additional targeted support in ways that suit them and they access services in good time.		<ul style="list-style-type: none"> • Reduction in Infant mortality • 1% reduction in smoking in pregnancy per annum • 1% reduction in low birth weight
1.1.1 Strengthen midwifery and stop smoking resources to reduce smoking in pregnancy	Linking pathways between acute and primary interventions and provide motivational interview training skills for Midwives	
1.1.2 Strengthen midwifery resources to provide health buddy support through pregnancy	<p>Giving priority to pre and post natal interventions including intensive home visiting with outreach to increase take-up from the most disadvantaged families</p> <p>Health buddy support -repeated broad based contacts with either a professional or peer educator both before and after birth to assist in take up of breast feeding and smoking cessation</p>	
1.1.3 Deliver effective campaign to promote good health and wellbeing in pregnancy	All women have access to good information and signposting to support lifestyle choices and wellbeing	
1.1.4 Ensure teenage mothers have additional support	<p>New ways of working: Children's Centres taking on the main role for providing tailored support to teenage parents including the facilitation of provision of specific education programmes within the young parent support groups.</p> <p>Reduction in greater prevalence of smoking among teenage mums in areas of deprivation. Smoking cessation support is available in new non medical places targeted to where mums will go- soft play centres, libraries, children centres.</p>	<p>For teenage mums-</p> <ul style="list-style-type: none"> • 1% reduction in low birth weight • 2% Increase breast feeding initiation rates • 2% Increase in breast feeding prevalence 6-8 weeks after birth • Reduce greater prevalence of smoking amongst teenage Mums in areas of deprivation
1a.1.5 Support pregnant women who are	Front line staff are given training and awareness raising about domestic violence, how to recognize it and what support is	

experiencing domestic violence	available NICE Guidelines for women with complex social circumstances implemented	
1a.2 Support infant feeding by achieving Unicef's Baby Friendly accreditation		
<p>The Baby Friendly Initiative works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.</p> <p>In whatever way a woman chooses to feed her baby health care professionals will make sure mums are supported and confident</p> <p>The Kent and Medway Infant feeding strategy will be fully implemented.</p>		<ul style="list-style-type: none"> • 2% Increase breast feeding initiation rates • 2% Increase in breast feeding prevalence 6-8 weeks after birth particularly in the most disadvantaged groups • Healthy Start Scheme
1a.2.1 Increase breast-feeding initiation rates and prevalence at 6-8 weeks	<p>Working through maternity units, hospitals, children centres, midwives and Health Visitors to achieve Unicef's baby friendly accreditation. Best practice is in place in a range of medical and community settings and Unicef's assessment and accreditation process is in progress recognising those that have achieved the required standard</p> <p>There will be a quarter on quarter increase in the uptake of the Healthy Start scheme-a statutory scheme providing a nutritional safety net and encouragement for breastfeeding and healthy eating for pregnant women and children under 4 in low income and disadvantaged families across the UK.</p>	
1a.2.2 Develop a needs assessment for breastfeeding to support targeting and commissioning of services	The needs assessment is being used to identify groups or areas where targeted support will increase breastfeeding	2% increase in breastfeeding rates in the most disadvantaged groups

Objective 1B: Give every child the best start in life (9 months+)

Priorities

1b. 1 Support parents so that they can raise emotionally and mentally healthy children

1b.2 Encourage access to health services for all

1b.3 Promote Healthy Weight for Children

1b.4. Increase childhood immunisations

Actions

1b.1.1 Provide clear and quick access through a redesign of child and adolescent mental health services (CAMHS).

1b.2.1 Make Information available about finding and registering with a G.P. and dentist through community settings

1b.3.1 Implement new recommendations for physical activity for under 5s in early years settings

1b.4.1 increasing childhood immunisations among Gypsy and Traveller children

1b.1.2 Targeted intervention through family nurse prevention or community budgets for families not engaged with services

1b.2.2 Families or young people who do not traditionally engage with services are supported to access health professionals

1b.3.2 Implement Healthy Weight Care pathway

1b.4.2 Introduce new ways and different settings to promote take up of childhood immunisations

1b.1.3 Identify and improve access to services for substance misusing parents

1b.3.3 Support access to physical activity and sport into adolescence

1b.1.4 Smoke free home initiative

Objective 1B: Give every child the best start in life (9 months+)

Priority 1b. 1 Support parents so that they can raise emotionally and mentally healthy children

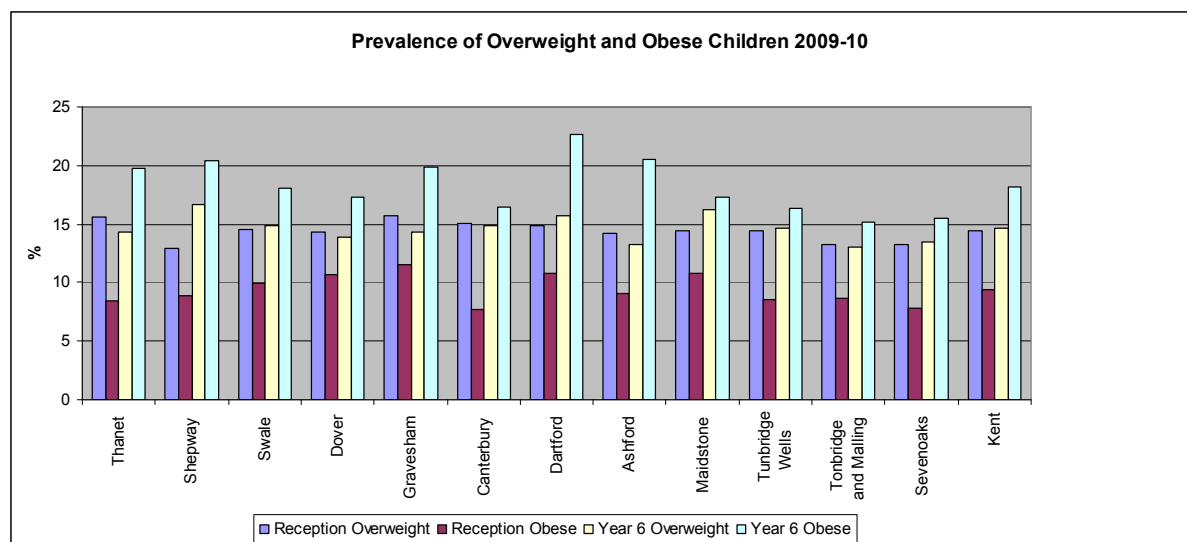
The role parents play in the health and wellbeing of their children cannot be overstated. Assisting parents to make the right choices to support healthy outcomes is a key part of tackling health inequalities for young people. The county council and districts are uniquely placed to communicate and support parents through children centres, schools, council services, libraries and Gateways and have a specialist family commissioning team to develop new services to support the most disadvantaged families in our communities

Priority 1b.2 Encourage access to health services for all

GP and Dentist registrations- access to health professionals is vital to support good health outcomes and finding and visiting a GP can be more difficult for those experiencing disruption in their lives- including looked after children and the homeless.

Priority 1b.3 Promote Healthy Weight for Children

Mounting evidence suggests that a critical period during which to prevent childhood obesity and its related consequences is before the age of five. The best thing we can do for children from 0-5 is create ways of life which continue to make obesity unlikely. Children who live in more deprived areas are more likely to be overweight and obese than those from the most affluent areas. Making what may seem like simple changes to daily habits (physical and nutritional) is sometimes simply too difficult given all



the other difficulties many families have to confront.

Source: The Health and Social Care Information Centre 2011

Priority 1b.4 Increase childhood immunisations

The national immunisation programme is an essential part of protecting children’s health. Low vaccine uptake puts children at risk. Measles has made resurgence in the UK and the rate of take up of the MMR vaccine in Kent whilst improving, is not at the 95% level recorded by the World Health Organisation as being necessary to prevent an outbreak.

Percentage of children immunised by their 5th birthday 2010-11

	DTP	Hib	DTPP	MMR	
	Primary %	Primary %	Booster %	First dose %	First and second dose %
West Kent PCT	93.7	94.9	91.4	92.3	87.4
Eastern & Coastal Kent PCT	96.3	96.7	90.1	93.5	87.0
South East Coast	92.5	92.6	84.4	89.0	80.9
England	94.7	94.2	85.9	91.9	84.2

Diphtheria Tetanus, Polio (DTP) Diphtheria Tetanus, Polio, Pertussis (DTPP) Information Centre 2011

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Local Profile
District comparison to the Health Authority average

X	Significantly worse than SHA average
-	Not significantly different from SHA average
√	Significantly better than SHA average

	Tooth Decay (at age 12)	Physically active children	Obese children yr 6
Ashford	-	-	X
Canterbury	-	√	-
Dartford	-	√	X
Dover	-	√	-
Gravesham	-	X	X
Maidstone	-	X	-
Sevenoaks	-	√	-
Shepway	√	X	X
Swale	-	X	-
Thanet	-	X	X
Tonbridge & Malling	-	√	-
Tunbridge Wells	-	√	-

Strategic

The Aspirations

Action	What good will look like in 2015	Targets and achievements
1b. 1 Support parents so that they can raise emotionally and mentally healthy children		
All our children have a right to a good childhood and a positive future. Parents and carers will feel supported to bring up their children to be physically, mentally and emotionally healthy, to help them fulfill their potential and equip them to contribute to society. Services will offer targeted support to those families that are finding it hard to cope or face challenging situations.		
1b.1.1 Provide clear and quick access through a redesign of child and adolescent mental health services (CAMHS)	CAMHS are easily accessible with short waiting times and improved access to psychological therapies Routine support to meet social need via outreach to families is available through schools, parenting programmes, children's centres and key workers	Access to and effective treatment from Camhs outcomes indicator
1b.1.2 Target family support to the most vulnerable families	Family nurse prevention and the community budgets model are used to engage families in deprived areas or those facing additional challenges There is access to effective parenting programmes. Children are ready for school and families are supported through the transition to school	Crude rate of hospital admissions caused by unintentional and deliberate injuries in age 0-17 per 100,00 resident population Childhood development at 2-2.5 years
1b.1.3 Identify and improve access to services for substance misusing parents		
1b.1.4 Smoke free home initiative	Reduce amount of second hand smoke children are exposed to by making smoking outside the house the acceptable social norm	
1b.2 Encouraging access to health services for all		

1b.2.1 Information is available about finding a G.P. and dentist through community settings	Health Trainers making Information about finding a G.P. and dentist and how to register available at Gateways, Children's centres, schools and libraries. Health Trainers engaging with Gypsy and Travellers to increase numbers registered with GP & Dentist	<ul style="list-style-type: none"> • LAC having a health check • Rate of tooth decay in children aged 5 years • Increasing immunisation
1b.2.2 Families or young people who do not traditionally engage with services are supported to access health professionals	Children and Young People from the following groups are able to get access to health services: <ul style="list-style-type: none"> • People with a learning disability • Looked after children • Homeless or in temporary accommodation • Gypsies and travellers 	
1b.3 Promote Healthy Weight for Children		
Measures for early intervention are targeted to areas of deprivation. Parents and carers are supported and informed in the early years about adopting good habits - how breast feeding and the introduction of good eating habits, physical activity and sleeping routines are likely to prevent the development of obesity. Children and young people have access to physical activity, sport at school, healthy food at school, affordable leisure activities and places to play		<ul style="list-style-type: none"> • From the 11/12 trend baseline we will aim to reduce the percentage increase from yr R to yr 6 by 1% per annum
1b.3.1 Implement new recommendations for physical activity for under 5s in early years settings	Healthy schools Team working in new ways with early years settings and rolling out the effective early years pilot to areas of deprivation Early years (under 5s) should be physically active daily for at least 180 minutes (three hours), spread throughout the day (once a child is able to walk.)	
1b.3.2 Implement Healthy Weight Care pathway	Improved referral rates to programmes from health care professionals to family healthy weight programmes such as MEND	
1b.3.3 Provide access to physical activity and sport into adolescence for all	Continue to develop opportunities and programmes with partners and the 3 rd Sector for young people to take part in sport – such as Sportivate and use the legacy of the 2012 Olympics and Para Olympics to promote the benefits of sport i.e. through the Kent school games Revise and promote the Active Kent website to provide	http://www.kentsport.org/ http://www.activekent.co.uk/

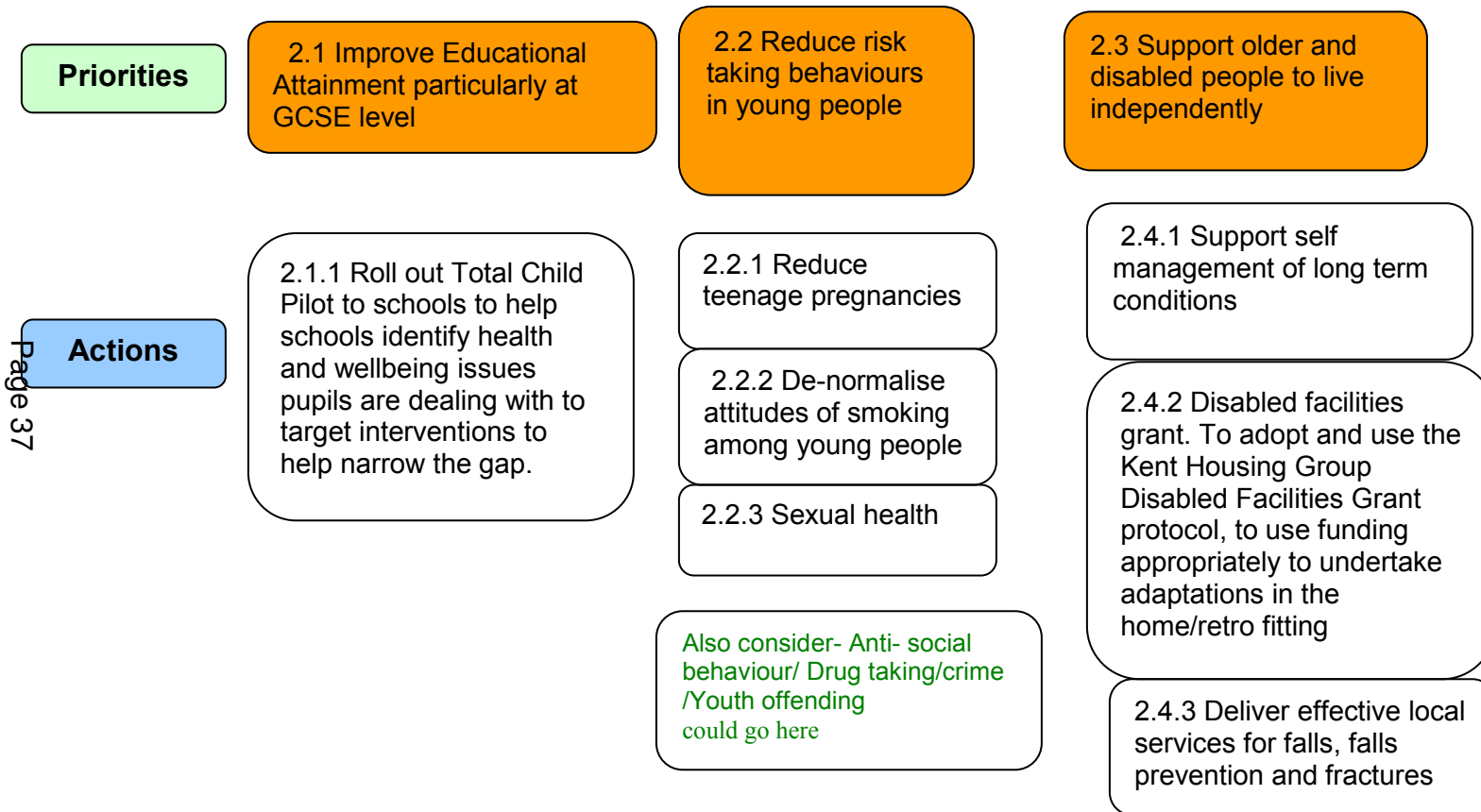
	information on local activities & services	
1b.4 Increase childhood immunisations among most vulnerable groups		
New, non medical places will be promoting and offering immunisations with specialist targeting to groups with low take up rates		<ul style="list-style-type: none"> • 1% Increase in immunisations take up by age 5 in groups with low take up rates
1b.4.1 Increasing childhood immunisations among Gypsy and Traveller children		
1b.4.2 Introduce new ways and different settings to promote take up of childhood immunizations	<ul style="list-style-type: none"> • Promoting take-up in children's centres • Start in school programme as part of primary school registration in most deprived areas • Targeted Opportunistic Vaccinations for children presenting at A& E 	

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2. Enable All Children, Young People And Adults To Maximise Their Capabilities And Have Control Over Their Lives

*Central to our vision is the full development of people's capabilities across the social gradient.
Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives
(Marmot review 20100)*

Objective 2: Enable all children, Young People and adults to maximise their capabilities & have control over their lives

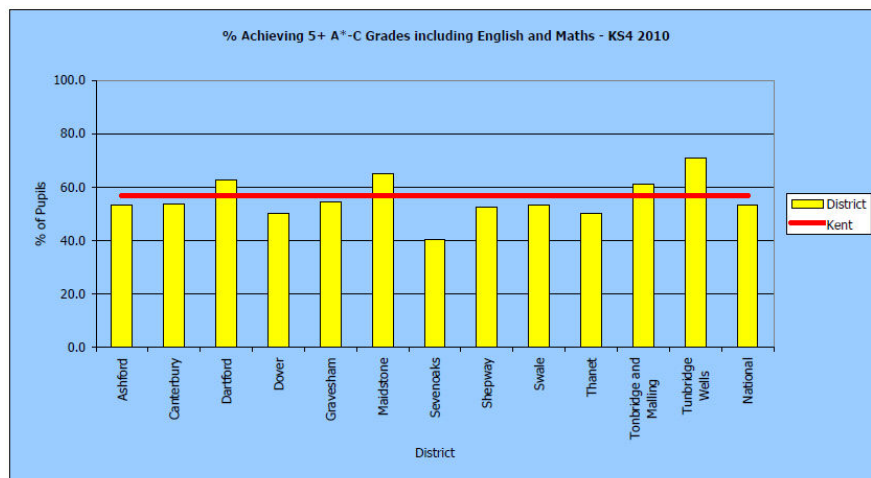


Objective 2: Enable all children, Young People and adults to maximise their capabilities & have control over their lives

Priority 2.1 Improve Educational Attainment particularly at GCSE level

There is a clear relationship between low educational attainment and poor health over a lifecycle. For young people educational attainment supports economic wellbeing- the ability to get and keep a job which indicates better mental wellbeing and health outcomes for the rest of their lives.

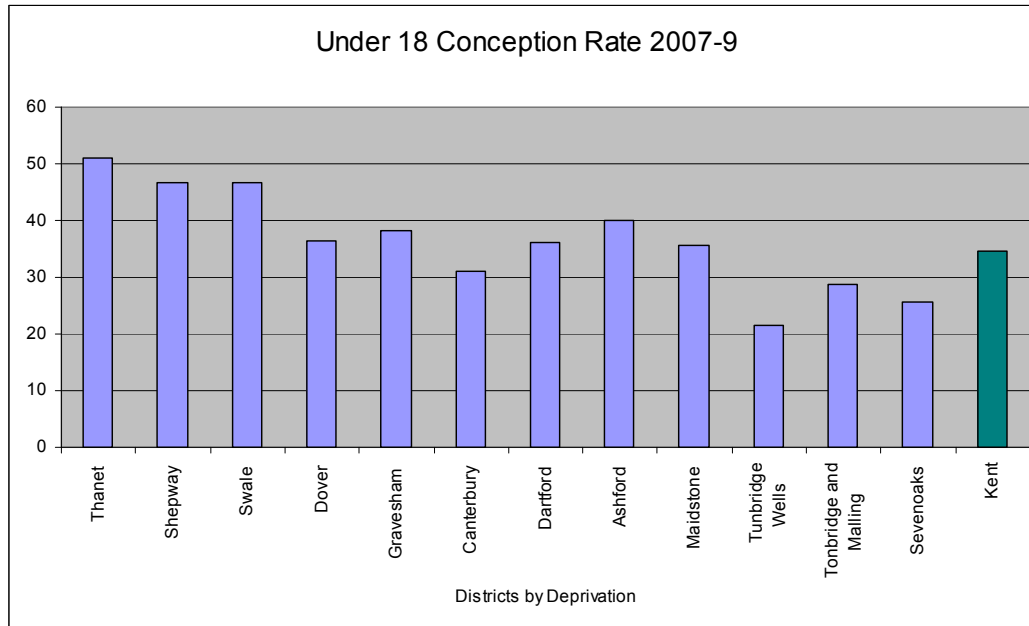
In 2009-10 GCSE statistics showed that around a third of pupils who had been on Free School Meals in the previous six years achieved five or more A*- C grades, compared to more than two thirds of their fellow pupils. In Kent, children who take free school meals experience marked inequality in comparison to the achievement of their peers- including significantly lower outcomes at GCSE. Those children achieving 5+ A*-C GCSEs are more likely to experience longer term employment and have the capability to retrain at least twice during a working life.



Whilst schools serving areas with significant concentrations of relative deprivation mainly do well against the England average they struggle to match the outcomes of the most affluent areas.

2.2 Reduce risk taking behaviours in young people

Teenage mothers and their children face particular inequalities: The link with a lack of aspiration is significant, young people need the motivation as well as the means to prevent pregnancy and engagement in education through the teenage years is a strong protective factor



In Kent the teenage pregnancy rate is 34.7 per 1000 females 15-17 years (2009) which compares favorably to an England rate of 38.

There is however significant difference in progress to reduce rates across the districts of Kent, with Canterbury having achieved the best reduction of 19% while Maidstone has demonstrated an increase of 10%.

(To avoid annual fluctuations rates are calculated on three year rolling averages.)

Sexual health: Sexually transmitted infections particularly affect young people and 15 to 24 year olds, particularly young women, continue to be the group most affected by sexually transmitted infections (STIs) in the UK or the group that most present for treatment. Untreated infection can lead to serious health problems, including infertility. Acute STIs diagnosed between 1998 and 2009, increased by 100% in the east Kent and west Kent clinics. Late diagnosis of HIV is a problem in some areas of Kent, for example almost 55% of HIV diagnoses in West Kent are classified as late diagnosis.

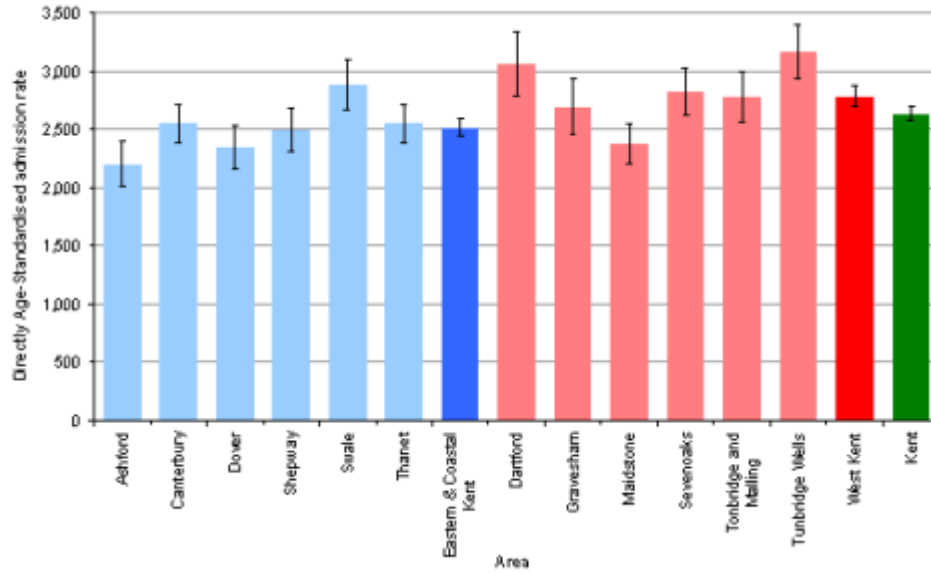
Priority 2.3 Support older and disabled people to live independently

Services that promote the health, well being and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities. (Marmot Review 2010)

For adults and older people having choice and control over their own situation not only reduces pressure on health and social care services it also supports people to live more fulfilled and independent lives.

Assistive technologies enable people with health and care needs, such as the frail elderly and those with Long Term Conditions (LTCs), to gain independence in their own homes. Evaluation of a recent pilot in Kent reported that people who use telehealth have fewer hospital admissions and shorter stays when they do, reduced GP contacts and in some cases fewer visits from community nursing teams. There was also an estimated saving of £7.5m to the health and social care economy.

Directly age-standardised rates for falls related hospital admissions per 100,000 population aged 65+ by Primary Care Trust and Local Authority district



Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, with large implications for the quality of life of older people who survive a fall. There are also considerable inequalities, both in terms of risk and longer term implications. For many older people a hip fracture is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% for one year. Tunbridge Wells, Dartford and Swale have the highest falls related admissions by District.

Local Profile

Districts compared to the Strategic Health Authority average

	Teenage pregnancy U18	Hospital stays for self harm	Hip fractures in Over 65s	GCSE achieved (5A*-c inc Eng & Maths)
Ashford	x	√	-	x
Canterbury	-	x	-	x
Dartford	-	-	-	√
Dover	-	x	-	x
Gravesham	x	-	-	x
Maidstone	-	-	-	√
Sevenoaks	-	√	-	x
Shepway	x	-	-	x
Swale	x	x	-	x

Thanet	x	x	x	x
Tonbridge & Malling	-	x	-	√
Tunbridge Wells	√	x	-	√

The Aspirations

Action	What Good Will Look like in 2015	Targets and achievements
2.1 Improve Educational Attainment particularly at GCSE level		
2.1.1 Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues pupils are dealing with to target interventions to help narrow the gap.	<ul style="list-style-type: none"> Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education Consistently implementing the full range of extended services in and around schools Developing the school-based workforce to build their skills in working across school– home boundaries and addressing social and emotional development, physical and mental health and well-being. 	<ul style="list-style-type: none"> Narrowing the gap between pupils on free school meals and their peers achieving 5* A-C Narrowing the gap between achievement across Districts
• 2.2 Reduce Risk taking Behaviours in young people		
2.2.1 Continue to implement Kent's teenage pregnancy strategy to reduce teenage pregnancies		<ul style="list-style-type: none"> Reduction in teenage pregnancy
2.2.2 De-normalise attitudes of smoking among young people		<ul style="list-style-type: none"> Reduce smoking prevalence rates among under 15 year olds Reduce illicit tobacco and supply of tobacco to under 18s
2.2.3 Improve sexual health by reducing late diagnosis of HIV in Kent and increase Chlamydia screening	<p>A range of targeted work will increase HIV testing</p> <ul style="list-style-type: none"> For Black African women Through MSM to increase early testing in high prevalence areas in Kent <p>Health care professionals will receive training to broach the topic of risk factors for STIs and work to increase Chlamydia screening in poor performing areas</p>	<ul style="list-style-type: none"> Reduction in late diagnosis of HIV by 1% Increase in take up of Chlamydia screening in Primary care In partners In young males
• 2.4 Support older or disabled people to live independently		

<p>2.4.1 Support self management of long term conditions</p>	<p>Mainstream use of assistive technology- telehealth & Telecare</p> <p>Recognising and making the most of opportunities presented to Public Health from the Integration of health and social care</p> <p>People with long term conditions will</p> <ul style="list-style-type: none"> • experience integrated, co-ordinated care in the community and will benefit from personalised interventions which enable them to become experts in their own condition. • have better outcomes in relation to physical and mental health, ability to carry out day to day activities and a reduced risk of acute hospital admission. • Their Carers will have an enhanced quality of life. <p>Community health and social care services will use risk stratification tools to target support to the right individuals at the right time.</p>	<ul style="list-style-type: none"> • People living independently in their own homes • Number of people accessing enablement and intermediate care services will meet “expected” targets • All people with LTC will benefit from social care personal budgets, personal health budgets or integrated personal budgets • Reduction in admissions to residential / nursing care • Reduction in emergency admissions • Reduction in emergency bed days • Reduction in admissions to residential and nursing care direct from hospital
<p>2.4.2 Disabled facilities grant. To adopt and use the Kent Housing Group Disabled Facilities Grant protocol, to use funding appropriately to undertake adaptations</p>		
<p>2.4.3 Deliver effective local services for falls, falls prevention and fractures</p>	<p>Services are reconfigured and commissioned to prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards</p> <ul style="list-style-type: none"> • acute and primary care-based fracture liaison service • community-based falls clinics • local authority-based postural stability community therapeutic exercise programmes 	

- | | | |
|--|--|--|
| | <ul style="list-style-type: none">• community/local authority-based falls call-out service(s),• Older and disabled people have access to home safety improvements | |
|--|--|--|

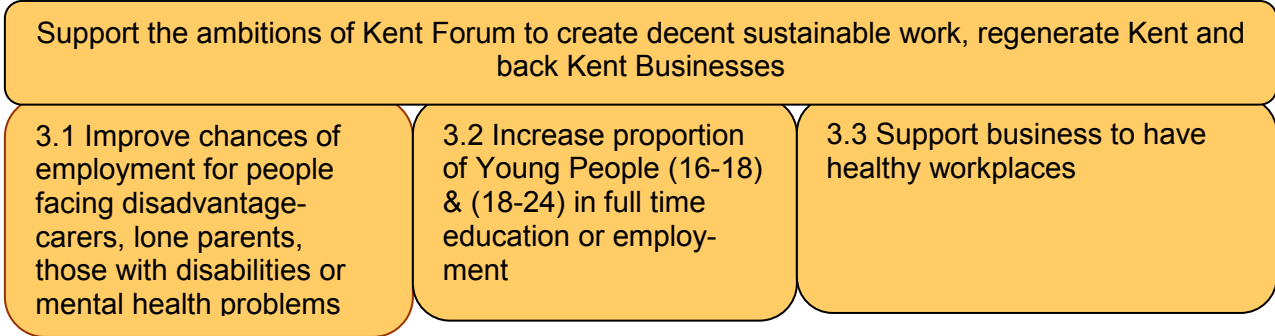
3. Create fair employment & good work for all

The recession is leading to increasing unemployment across Kent. Marmot says that work is good – and unemployment bad – for physical and mental health.

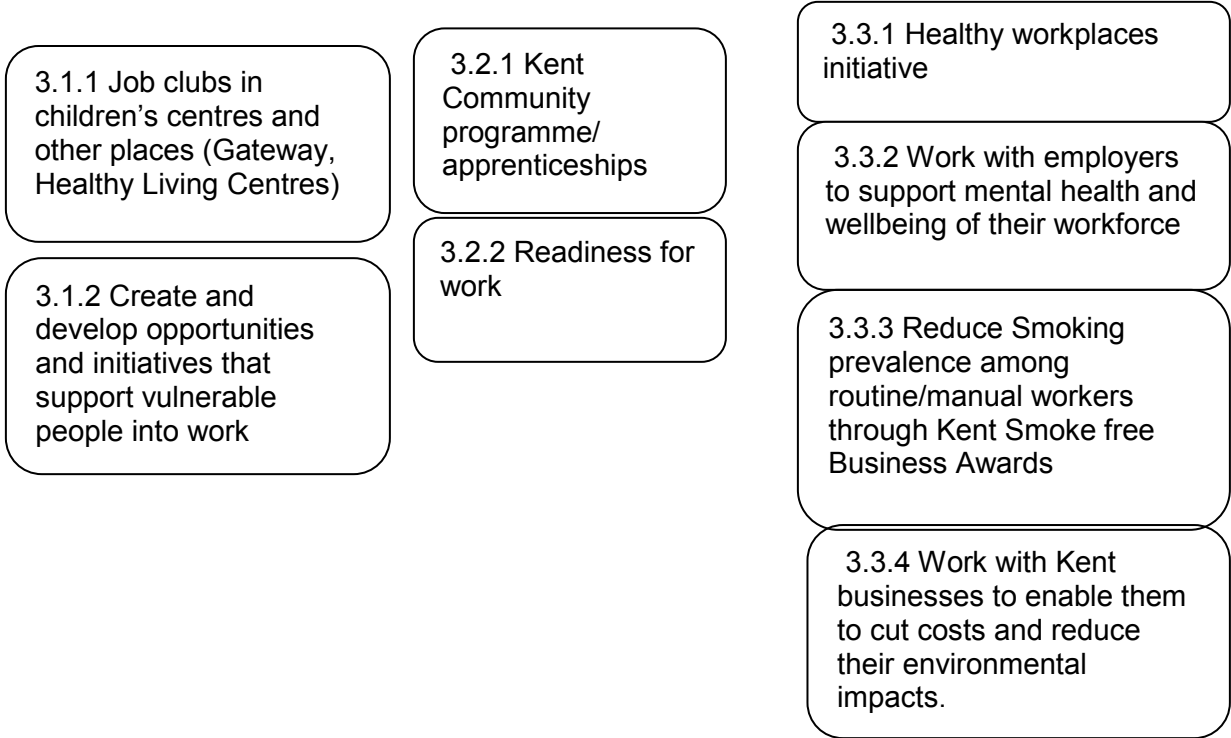
However the quality of work is also important with underlying low levels of stress connected to low paid and insecure work in poor conditions contributing to poorer health outcomes. Work cannot provide a sustainable route out of poverty if job security, low pay and lack of progression are not also addressed

Objective 3 Create fair employment & good work for all

Priorities



Actions



Objective 3 Create fair employment & good work for all

Priority 3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with disabilities or mental health problems

Disabled workers, those with low or no qualifications and lone parents are among the groups of people most likely to find themselves long-term unemployed. (Begum 2004) With fewer jobs available it is likely that unemployment rates for all vulnerable groups will increase- causing an increase in demand for support from Health, Welfare and Social Care services

	Eastern and Coastal Kent	West Kent PCT	England Average
% of adults with mental health problems aged 18-69 in contact with secondary mental health services who were known to be in paid employment at the time of their assessment or latest review. 2009	5.2%	5.8%	7.9%

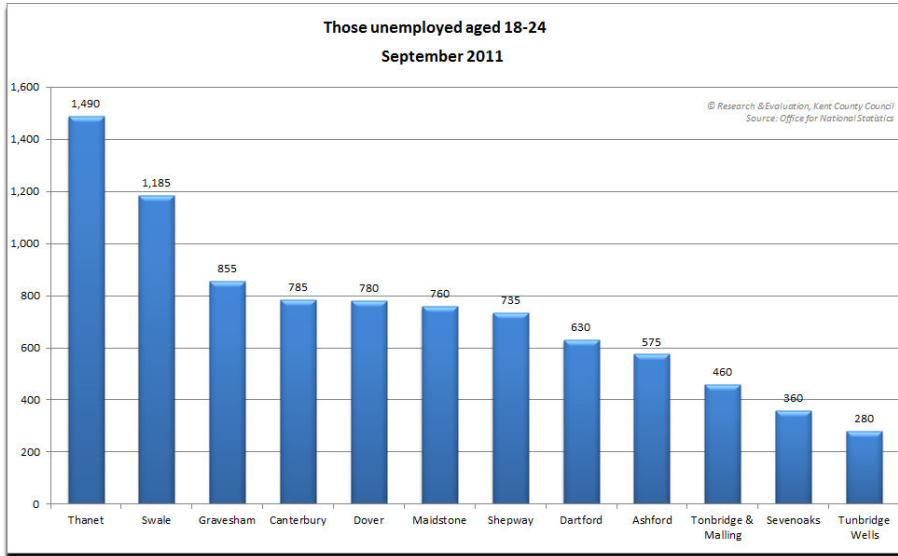
The employment rate for people who are disabled in the KCC area is 51.9%, this is lower than the employment rate for people without a disability which is 78.4% in the KCC area. This is below the South East average rate of 55.7% but above the national average rate of 48.8%.

The difference in employment rates also varies across the KCC area. In Ashford t the employment rate for people with a disability is 69.0% and for those without the rate is 79.3%, however in Thanet t only 42.2% of disabled people are in employment as opposed to 80.0% of people without a disability.

As of May 2011 nearly 34,000 lone parents were claiming income support. (11,000 men, 22,000 women) Benefit reforms are expected to have the most impact on unemployed, lone, female parents causing them to be worse off financially.

Priority 3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment

Young people continue to be disproportionately affected by the economic downturn with those aged 18-24 making up the biggest proportion of unemployed in the KCC area. Again areas of deprivation are experiencing the biggest impact and the social gradient can be clearly demonstrated



Research has shown that being NEET between the ages of 16 and 18 is a major predictor of future unemployment, low income, teenage parenting and poor health. Young people who are NEET are also 5 times more likely to enter the criminal justice system, with the life-time cost to the state of each young person who is NEET standing at £97,000.

Kent continues to perform well in decreasing the numbers of young people who are NEET and is below the National and South East average. However performance varies across Districts, with Thanet, Maidstone, Swale and Shepway historically having higher numbers of NEET (16-18). Young people with special educational needs (SEN), offending behaviour, health issues and looked after children (LAC) all perform poorly in comparison with their peers.

Local Profile

Districts comparison to the Strategic Health Authority average

	Long term unemployment
Ashford	√
Canterbury	√
Dartford	x
Dover	-
Gravesham	x
Maidstone	√
Sevenoaks	√
Shepway	x
Swale	x
Thanet	x
Tonbridge & Malling	√
Tunbridge Wells	√

The Aspirations

Action	What Good will look like in 2015	Targets and achievements
3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with disabilities or mental health problems		
3.1.1 Job clubs in children's centres and other places (gateway, Healthy Living Centres)	Employers have been encouraged/ incentivized to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems	Employment of people with long term conditions
3.1.2 Create and develop opportunities and initiatives that support vulnerable people into work	<ul style="list-style-type: none"> • Maximise opportunities to support people into work through initiatives such as <ul style="list-style-type: none"> ○ Kent Supporting People ○ Kent Supported Employment • Support development of Social enterprises with the voluntary sector • Work with employers and service users to support sustainable employment for people with mental health problems 	Employment of people with mental health problems
3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment		
3.2.1 Kent Community programme/ apprenticeships		
3.2.2 Readiness for work	<p>Partners have worked with employers to gain an understanding of what skills the employers of Kent want and educational settings have come together to ensure training, work opportunities or further education is targeted to these skills</p> <p>Providing support and advice for 16–25 year olds on life skills, training and employment opportunities, delivered through centres that are easily accessible to young people</p> <p>Kent's number of NEETS remains low</p>	Rate of young people who are NEETS
3.3 Support business to have healthy workplaces		
3.3.1 Healthy workplaces initiative		

3.3.2 Work with employers to support mental health and wellbeing of their workforce	Wellbeing of staff is a priority, especially in the context where many are being made redundant and workloads are increasing.	
3.3.3 Reduce Smoking prevalence among routine/manual workers through Kent Smoke free Business Awards		<ul style="list-style-type: none"> • Smoking prevalence in routine and manual workers
3.3.4 Work with Kent businesses to enable them to cut costs and reduce their environmental impacts		

4 Ensure healthy standard of living for all

Having insufficient money to lead a healthy life is a highly significant cause of health inequalities

(Marmot Review 2010)

Objective 4: Ensure healthy standard of living for all

Priorities

4.1 Support financial capacity and inclusion

4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)

Actions

4.1.1 Continue to promote Kent Credit Savers Union to enable people to smooth their incomes and have access to affordable credit

4.1.2 Provide financial advice as to how best to manage debts and household budgets in general.

4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks

4.2.1 Access to free or affordable childcare places to help people work

4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go

4.2.3 Provide information and signposting for older people who may be struggling to heat their homes

Objective 4: Ensure healthy standard of living for all

Financial security is recognised within the Marmot Review as a social determinant of health, specifically through the concept of the 'social safety net'.

Deprivation is associated with a cluster of health problems including higher levels of unhealthy weight and obesity, physical inactivity, smoking, poor blood pressure control, and other factors that effect physical health. It is also integral to lower educational attainment, lack of employment opportunities, poor housing status, poor access to services, referral differences of practitioners and poor compliance with disease management

Priority 4.1 Support financial capacity and inclusion

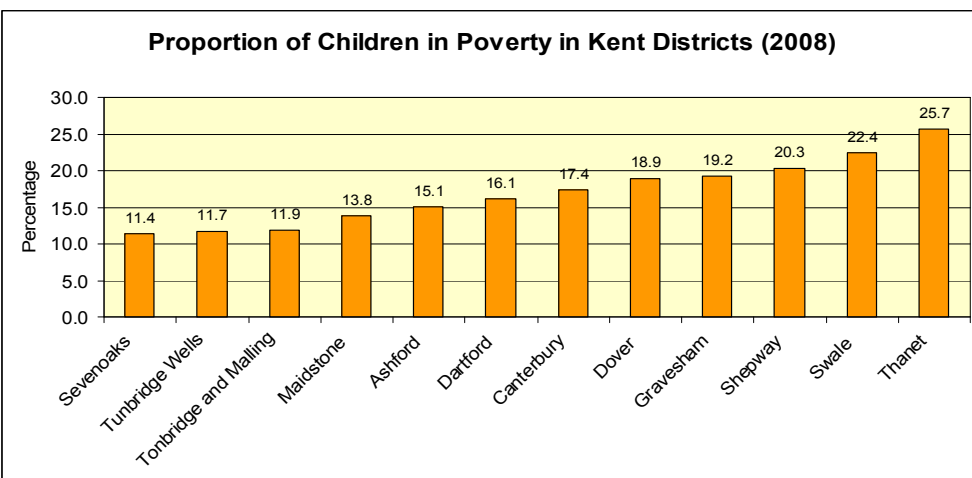
This is particularly relevant now when greater financial responsibility and engagement is being asked of people, whether that is managing care needs in retirement or managing personalised health and social care budgets.

A credit union provides access to fair and affordable credit that allows people to smooth peaks and troughs of income. Conversely, overindebtedness is causing real misery for households and communities. 8 in 10 financially excluded individuals live in social housing.

Poor financial skills can result in debt:

"It is due to negligence on my part and not having enough experience of handling money when I moved out of my parents' home."
from A Life in Debt- The profile of CAB debt clients in 2008

Priority 4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)



The most recent data available at a local level is for child poverty in 2008. This shows 17% of children living in Kent as living in poverty, compared to a national figure of 21%, and equates to over 53,000 children. Within Kent there is considerable variation across districts ranging from 11% in Sevenoaks to 26% in Thanet.

Childcare availability, cost and quality, can be an issue for parents, particularly those of young children. Cost can make low-paid work financially unviable; care is also sometimes not flexible enough, with parents unable to find care for evenings, weekends, at short notice, and in school holidays. In Kent it is estimated that a total of 4,409 additional childcare places are required across Kent and the most significant need for additional places occur within the most deprived areas of Kent.

Local Profile

Districts that are performing significantly worse than the Strategic Health Authority average

	Deprivation	Proportion of Children in Poverty	Life expectancy - female	Life expectancy - male
Ashford	√	-	-	√
Canterbury	√	X	X	X
Dartford	√	X	X	-
Dover	X	X	X	X
Gravesham	X	X	X	X
Maidstone	√	√	-	-
Sevenoaks	√	√	-	√
Shepway	X	X	-	X
Swale	X	X	X	X
Thanet	X	X	X	X
Tonbridge & Malling	√	√	√	√
Tunbridge Wells	√	√	√	√

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The Aspirations

Action	What Good will look like in 2015	Targets and achievements
4.1 Support financial capacity and inclusion		
4.1.1 Continue to promote Kent Credit Savers Union - Kent's credit Union, to enable people to smooth their incomes and have access to affordable credit	Kent credit union is being used by local people with regular promotions to local authority staff and local communities.	
4.1.2 Provide financial advice as to how best to manage debts and household budgets in general	Money management for Vulnerable Young people extended from schools to HOUSE & Youth Hubs – possibly delivered by Healthy Schools Team. Continue to provide free hosting for CAB at	

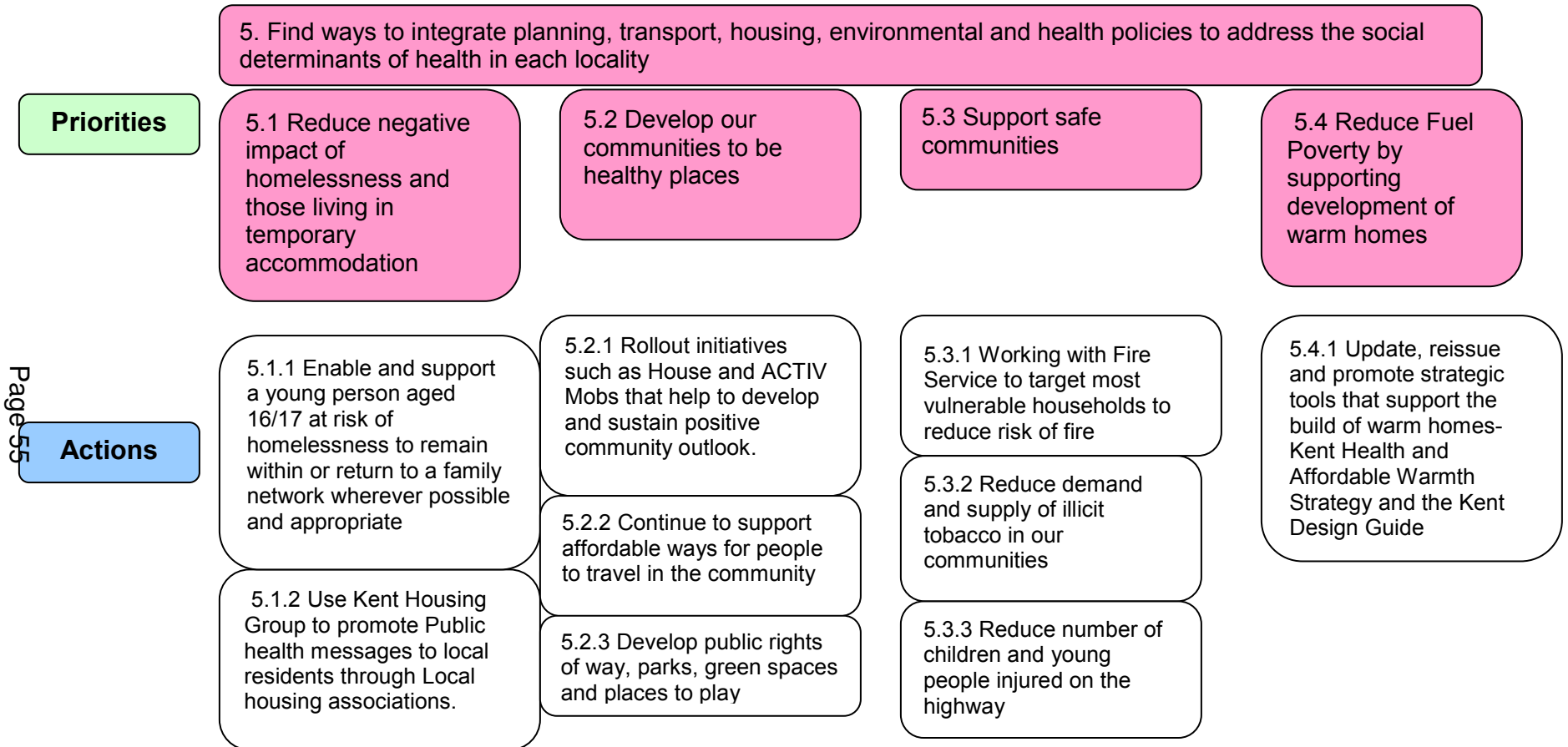
	Gateways	
4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks	Signposting, advice and guidance available from kent.gov.uk and partners sites.	
4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)		
4.2.1 Access to free or affordable childcare places to help people work	Increase in affordable child care places	Reduction of number of children in poverty
4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go		
4.2.3 Provide information and signposting for older people who may be struggling to heat their homes	Keep Warm in Winter campaign signposting to benefits and energy saving measures	

5. Create and Develop Healthy and Sustainable Places & Communities

Dream with me of a fairer world, but let us take the pragmatic steps necessary to achieve it

Sir Michael Marmot October 2011

Objective 5: Create and Develop Healthy and Sustainable Places & Communities



Objective 5: Create and Develop Healthy and Sustainable Places & Communities

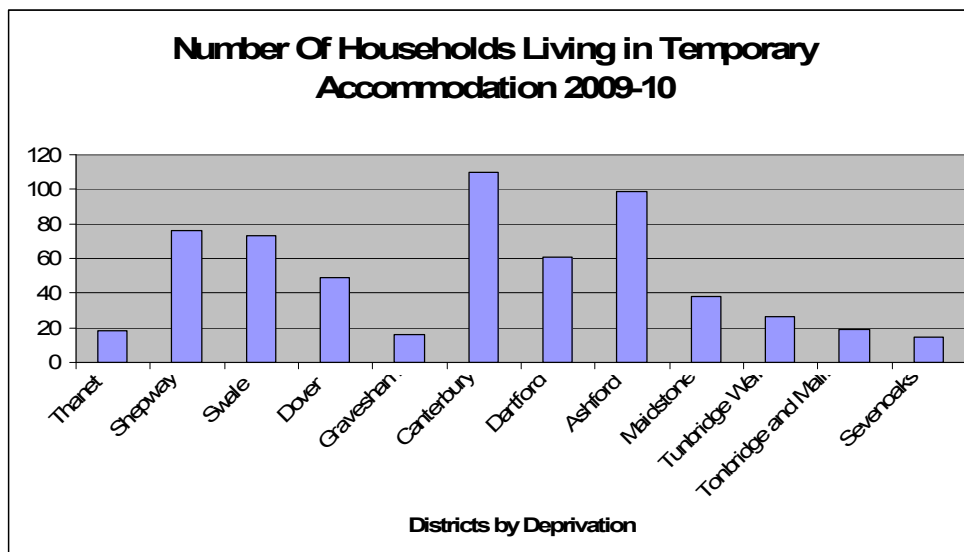
Promoting wellbeing is at the heart of what local government is about: supporting a better life for its citizens and helping to build resilient communities, now and over the longer term

5.1 Reduce negative impact of homelessness and those living in temporary accommodation

- The number of households being made homeless is increasing in Kent due to the recession, rising unemployment and cost of living so that families are finding themselves unable to meet the cost of mortgages and rent. From April to June 2011 Kent local authorities made 588 decisions on applications for housing assistance. This is 43% higher than the same quarter in 2010. Of the 588 decisions 229 households were accepted as homeless, an increase of 13% compared to one year ago.
- Districts have made significant improvements from more than 1,800 households living in temporary accommodation in 2004/05 to 583 in 2009/10
- Many homeless young people are placed in temporary accommodation, including Bed & Breakfast. Homeless young people are often very vulnerable, have multiple needs and are in need of support as well as accommodation. Most recent data shows that young people leaving care in Kent (2009-10 data) and young offenders (2008-9) are less likely to find suitable accommodation than is the case nationally and across our statistical neighbours

Shelter Living in limbo: Survey of homeless households living in temporary accommodation 2004

- Over half of people said that their health or their family's health had suffered due to living in temporary accommodation
- Children had missed an average of 55 school days due to the disruption of moves into and between temporary accommodation
- Two thirds of respondents said their children had problems at school; and nearly half described their children as 'often unhappy or depressed'
- Over three quarters of households (77 per cent) had no family member working. The reasons for this included health or mobility problems, the insecurity of their accommodation, high rents and worries about changes to benefits



Priority 5.2 Develop our communities to be healthy places

Within our county there are health inequalities that are differentiated geographically. Local authorities are the planning authorities for their areas and, as such, have huge opportunities to influence both the infrastructure and the services provided in an area.

In general 20% of households cannot afford a car. Data for Kent shows that 20.5% of lower super output areas in Kent (181 small areas) are within England's most deprived 20% of areas experiencing barriers to housing and services (home ownership and road distance to key services such as GP, primary school , post office, supermarket). Deprivation related to barriers to housing and services is concentrated in rural areas. This is partially related to the distance people live from services in rural areas but also because of difficulty people in rural areas have entering owner-occupation.

Priority 5.3 Support safe communities

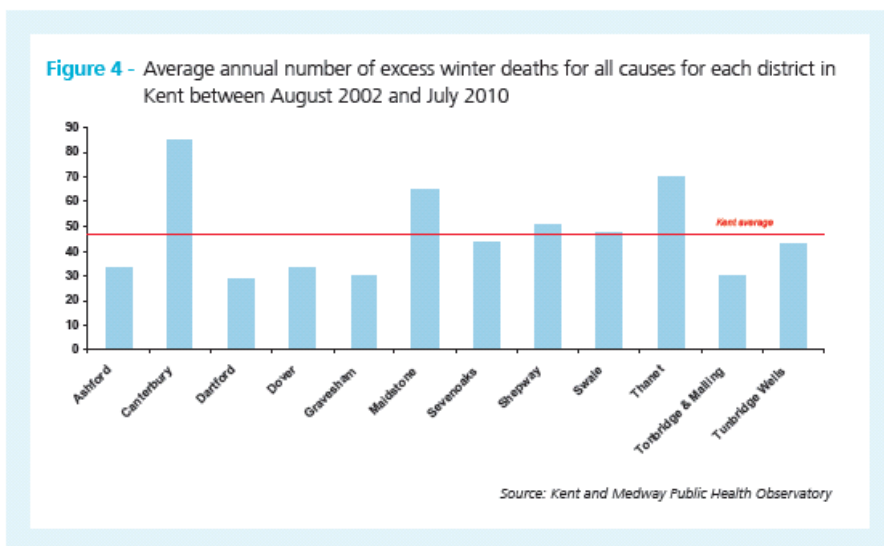
- **Road Safety:** Injury is not only most often the cause of child death in the UK, but also has a steeper social class gradient than any other cause of child death. Casualty rates for child pedestrians are estimated to be five times higher in the most affluent than least affluent wards (Social Exclusion Unit 2003). Traffic calming, design which encourages cycling and discourages car use and parking in the least affluent areas are all part of the contribution local government can make to improving health and reducing health inequalities.

- Fire Safety: In 2010-11 Kent Fire and rescue services attended 677 accidental dwelling fires. 2 people died and 77 people were injured as a result of accidental fires. In Kent there are on average 46 fires per year in households and household dwellings caused by smoking. This results in a total cost of £1,150,000 pa in Kent. A child from the lowest social class is nine times more likely to die in a house fire than a child from a well off home.

Priority 5.4 Reduce Fuel Poverty by supporting development of warm homes

Fuel poverty, is said to occur when people in a household need to spend more than 10 percent of their income total in order to heat their home. 6% of households in the KCC area are estimated to be living in fuel poverty. This is approximately 33,000 households. This proportion is higher than the South East average (5.7%) but slightly lower than the national average (6.1%). Of all Kent districts, Thanet has the highest number and proportion of households estimated to be living in fuel poverty, (3,654 Thanet households, which is equivalent to 6.6% of all Thanet households). Dover (6.5%), Swale (6.3%) and Shepway (6.2%) also have a higher estimated proportion of households in fuel poverty compared to the national average.

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The people most likely to die or become ill during the cold weather are those least able to afford to heat their homes. For every one degree Celsius that the outdoor temperature falls below the winter average, there are an 8,000 extra winter deaths in England. This would equate to an estimated 240 deaths across Kent. Living in a cold home can lead to or worsen a large number of health problems including heart disease, stroke, respiratory illness, falls, asthma and mental health problems.

Local Profile

Districts comparison to the Strategic Health Authority average

	Excess Winter Deaths	Road Injuries and deaths- all ages	Violent Crime	Statutory Homelessness
Ashford	-	-	√	x
Canterbury	-	√	√	√
Dartford	-	-	x	x
Dover	-	-		-
Gravesham	-		x	x
Maidstone	-	-	-	
Sevenoaks	-	-		-
Shepway	-	√	x	x
Swale	-	√	x	-
Thanet	-	√	x	-
Tonbridge & Malling	-	-	√	√
Tunbridge Wells	-	-	√	-

The Aspirations

Action	What Good will look like in 2015	Targets and achievements
5.1 Reduce negative impact of homelessness and those living in temporary accommodation		
5.1.1 Enable and support a young person aged 16/17 at risk of homelessness to remain within or return to a family network wherever possible and appropriate	<p>JPPB to monitor and review Dartford pilot on joint preventative services between housing and FSC children's department re homeless 16/17 year olds and roll out across Kent</p> <p>Fewer young people becoming looked after at age 16/17</p> <p>Reduced dependency on the state at age 19</p> <p>Strengthen positive relationships within family and social networks</p>	Reduction in numbers living in temporary accommodation
5.1.2 Use Kent Housing Group to promote Public health messages to local residents through Local housing associations		
5.2 Develop our communities to be healthy places		
5.2.1 Rollout initiatives such	Relatively small scale interventions designed in partnership with local	House and House on

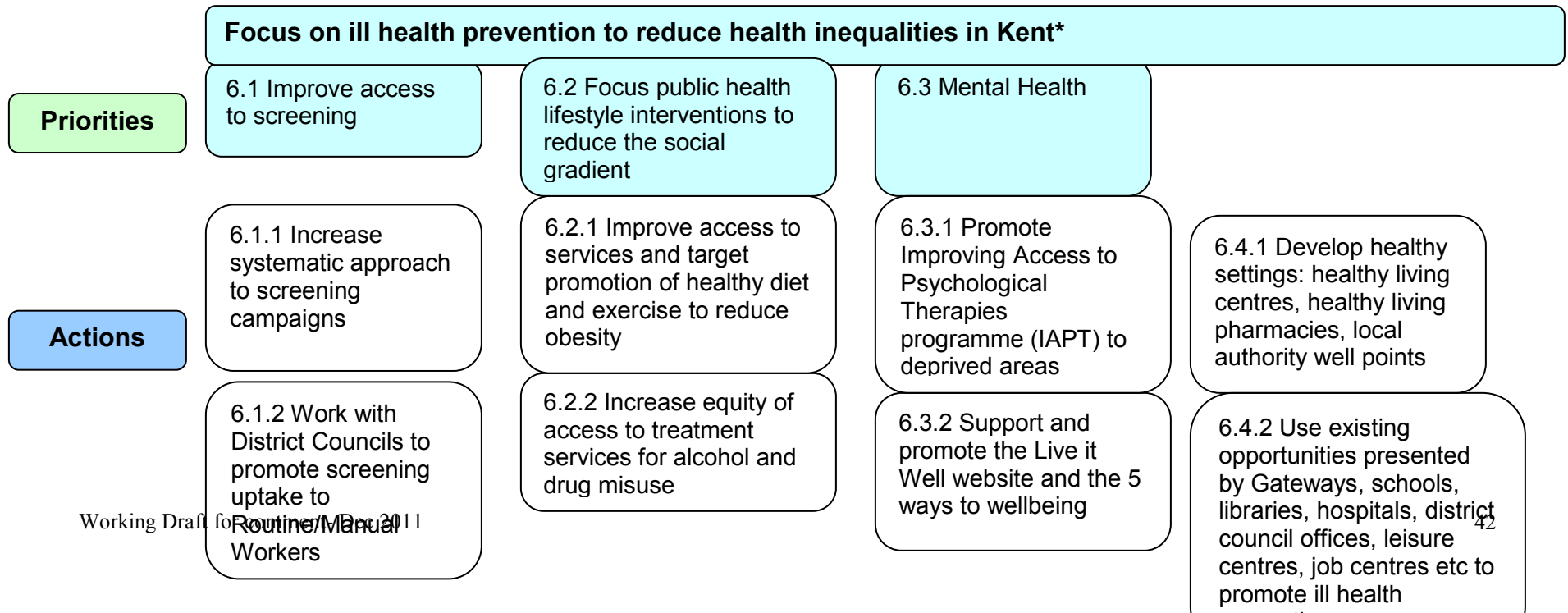
as House and ACTIV Mobs that help to develop and sustain positive community outlook.	residents, forming part of wider good quality and sustained neighbourhood working, (family poverty Report recommendation)	the Move available to young people in town centres
5.2.2 Continue to support affordable ways for people to travel in the community	<p>Increasing active travel across the social gradient and ensure health inequalities are being addressed by this initiative by</p> <ul style="list-style-type: none"> analysis of postcodes data for purchasing the Kent Freedom Pass and in the future concessionary bus passes. Evaluation and outcomes of Cycle Instruction and Walking Schemes targeted to schools in deprived areas, including bike loan/and or repair 	Take up of Freedom passes, concessionary bus passes.
5.2.3 Develop public rights of way, parks, green spaces and places to play	Improving access and quality of public rights of way, open and greenspaces available across the social gradient. Through the Explore Kent website people are signposted to accessible places to go and free events such as guided walking so everyone can get involved	
5.3 Develop our communities to be safe places		
5.3.1 Working with Fire Service to target most vulnerable households to reduce risk of fire	<p>Increase the number of above and well above average risk home safety visit referrals from partner agencies</p> <p>Increase No. of sprinkler installations in vulnerable homes</p>	Reduction in accidental fires in dwellings
5.3.2 Reduce demand and supply of illicit tobacco in our communities	Reduction in supply of illicit tobacco	1% Reduction In Smoking Prevalence rate per annum
5.3.3 Reduce number of children and young people injured on the highway	<p>Walking and cycling initiatives, including walking and cycling to school projects and campaigns</p> <p>Continuing programme of targeted Road Safety projects that have been reviewed and evaluated as effective-e.g.</p> <p>Small Steps – pedestrian training</p> <p>Cycle Instruction</p> <p>B-Viz – campaign to improve visibility especially in winter months</p> <p>Schools continue to produce and promote travel plans</p>	Reduction in road accidents to children
5.4 Reduce Fuel Poverty by supporting development of warm homes		

5.4.1 Update, reissue and promote strategic tools that support the build of warm homes- Kent Health and Affordable Warmth Strategy and the Kent Design Guide	Better/improved joint working between housing and health partners to ensure that homes are warm and safe leading to prevention of falls/COPD/Heart problems, good mental health	Reduction in Excess winter deaths Proportion in fuel poverty
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6. Strengthen the role and

*Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition.
(Marmot Review 2010)*

Objective 6: Strengthen the role and impact of ill health prevention



6.1.3 Increase Health Check programme among those in most deprived areas to ensure early screening and diagnosis

6.2.3 Reduce smoking prevalence with a focus on socio economic groups most likely to smoke (see also objective 3)

6.3.3 Deliver the mental health impact assessment tool in key locations

6.3.4 Deliver mental health awareness via healthy living centres in deprived areas

6.4.3 Continue to research and gain understanding of health inequalities within our communities and how best to support them to help target scarce resources

*See also Sexual Health and falls in section 2

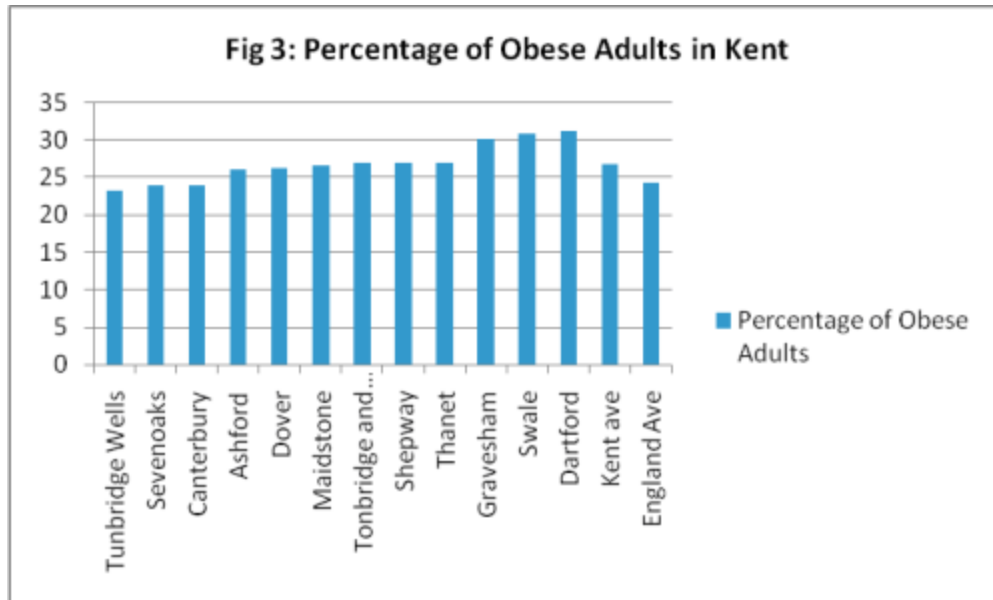
Objective 6: Strengthen Ill Health Prevention

Priority 6.1 Improve access to screening

The aim of national screening is to reduce the amount of disease in a population, or to detect disease at an early stage to improve patient outcome. The most deprived and ethnic minority groups are less likely to take up screening. The incidence and prevalence of vascular diseases reflect health inequalities in the UK and the widening gaps in life expectancy between the most and the least disadvantaged in society. Gaps in life expectancy across west Kent, for example, can be as high as 14 years. There are also inequalities in the uptake of cervical cancer screening through low uptake amongst younger women with only 69% coverage across Kent for those aged 25-29.

Priority 6.2 Focus public health lifestyle interventions to reduce the social gradient

Obesity: Adult obesity is far more prevalent in socially disadvantaged groups. It is estimated that approximately 28% of the Kent population is obese (354,022).



Source: Health Profiles 2010 APHO and Department of Health

Smoking: Smoking prevalence in Kent is 24.9%, however there is a significant amount of variation across Kent and it is a major reason for our health inequalities. Routine and manual smokers represent the single biggest group of smokers –half of all smokers belong to the routine and manual group

Of the 11,250 deaths of Kent residents aged 35 and over in 2008, approximately 2,250 (20%) can be attributed to smoking. Approximately 10,300 hospital admissions of Kent residents aged 35 and over in 2008 can be attributed to smoking (5% of the total 205,932 admissions). The majority of these are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease.

Table 7 Cost burden of obesity to SEC PCTs 2006

PCT	NHS Cost of principle diseases related to obesity (millions)
Eastern and Coastal Kent	279.2
West Kent	221.4

Alcohol Misuse: The impact of alcohol misuse is widespread; it encompasses alcohol related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. Health inequalities are clearly evident as a result of alcohol-related harm; national data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation. It is estimated that 259,103 adults in Kent are drinking at ‘increasing risk’ levels or ‘high risk’ levels. In 2009-10 the equivalent of 24,682 people in Kent were admitted to hospital for alcohol related harm, costing over £45 million.

Substance Misuse: There are strong links between levels of deprivation, prevalence of problem drug use, drug related hospital admissions and mortality. Estimates indicate that there are between 3640 and 7591 problem drug users in Kent and that a further 2500 problem drug users are not engaged with services. Hospital admissions continue on an upward trend.

Priority 6.3 Mental Health

People with mental health problems are more prone to factors that lead to worse health outcomes, such as poor diet, smoking, drug and alcohol misuse and low rates of physical activity. Higher rates of heart disease, stroke, high blood pressure, breast and bowel cancer and diabetes are experienced by people with a serious mental illness. The Mental Health Joint Strategic Needs Assessment for Kent and Medway estimates that there are more than 60,000 people estimated to have severe mental illness, and around 12,000 people are estimated to have severe and enduring mental illness.

Drug-specific admissions (primary diagnosis) per 100,000	2006/7	2007/8	2008/9	2009/10	2010/11
All Kent	14.21	16.72	10.14	15.81	16.77
East Kent	14.84	17.75	11.36	16.67	18.20
West Kent	12.86	15.26	9.36	14.53	15.79

Priority 6.4 Grow partnerships and find new ways to deliver services in places where people go

Reducing barriers so that everyone, but especially those dealing with stigmatization or discrimination is able to access health services as locally as possible.

Local Profile

Districts comparison to the Strategic Health Authority average

	Heart disease & stroke	Early death-cancer	Obese adults	physically active adults	Healthy eating adults	People diagnosed with diabetes	Smoking related deaths	Drug Misuse	Hospital Stays for alcohol related harm	Adults smoking
Ashford	-	-	x	-	-	x	x	x	x	x
Canterbury	-	-	-	-	-	x	x	x	x	x
Dartford	x	-	x	x	x	-	-	-	-	-
Dover	x	-	x	-	-	x	x	x	x	x
Gravesham	-	-	x	-	-	-	-	-	-	-
Maidstone	-	-	-	-	-	√	√	√	√	√
Sevenoaks	√	-	-	-	-	√	√	√	√	√
Shepway	x	-	-	-	-	x	x	x	x	x
Swale	x	x	x	-	x	x	x	x	x	x
Thanet	x	x	x	x	x	x	x	x	x	x
Tonbridge & Malling	-	-	-	-	-	-	-	-	-	-
Tunbridge Wells	-	-	-	-	-	√	√	√	√	√

The Aspirations

Action	What Good Will Look Like in 2015	Targets and achievements
6.1 Improve access to screening		
6.1.1 Increase systematic approach to screening campaigns	<p>There will increasing take up from groups who traditionally do not attend screening. Work will have been undertaken to:</p> <ul style="list-style-type: none"> review variations in the uptake and coverage of all cancer screening programmes and commission programmes to maintain national standards and to reduce local health inequalities. develop commissioning framework for the local implementation of the HPV triage for cervical cancer screening. support and monitor the implementation of age extension for Breast Cancer Screening Programme. develop commissioning framework for the local implementation of age extension for Bowel Cancer Screening Programme 	<p>Proportion of aged 53-64 women who have been successfully screened for breast cancer (+ %)</p> <p>Mortality from all cancer, direct age standardised rate for persons <75yrs</p> <p>Increase in numbers of young women taking up cervical screening....</p>
6.1.2 Work with District Councils to promote screening uptake to		

Routine/Manual Workers		
6.1.3 Increase Health Check programme among those in most deprived areas to ensure early screening and diagnosis	NHS Health Check programme employing more targeted delivery via alternative providers, from non-clinical, non-NHS sites, so that those with the greatest health needs are effectively reached by the programme JSNA	Health checks' are to be provided to people between 40 and 74 years across Kent. With full roll out 880,211 checks are to be delivered across Kent on an annual basis from 2013
6.2 Focus public health lifestyle interventions to reduce the social gradient		
6.2.1 Improve access to services and target promotion of healthy diet and exercise to reduce obesity	The Health Trainer service had been developed to target those in areas of high deprivation. Pathways from services into lifestyle behaviour programmes are clear and easily accessible so that people at risk following a health check or coping with chronic conditions where diet and physical activity would make a difference have improved outcomes. Services have been reviewed, are fit for purpose and provide quality interventions.	Slow the increase in obesity in adults by 1% per annum
6.2.2 Increase equity of access to treatment services for alcohol and drug misuse	<ul style="list-style-type: none"> Industrialising opportunistic Identification and Brief Advice (IBA) for those at risk through alcohol misuse as part of Healthy Lifestyles services through local authority commissioning for prevention. Increased awareness and support to veterans regarding substance and alcohol misuse and mental health (also ex offenders have been mentioned) For problem drug users structured counselling, intensive family based interventions, practical group work activities and better links with mental health services will be used to develop relevant social skills that increase service users capacity to sustain long term improvements in terms of substance use and their health and social functioning. Recovery focused intensive keyworking will also provide a specific focus throughout the treatment journey (JSNA) 	<p>1% reduction in hospital stays for alcohol related harm per annum</p> <p>1% reduction in drug misuse</p> <p>Commission IBA in a variety of clinical settings for at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years using referral tools and pathways already agreed by commissioners and providers</p>
6.2.3 Reduce smoking prevalence with a focus on socio economic groups most likely to smoke (see also objective 3)	<p>Assessment of risk factors for early identification of people with COPD and Lung cancer has led to more effective targeting of services leading to evidence of smoking prevalence reduced in cohorts:</p> <ul style="list-style-type: none"> - Routine/Manual workers in Kent - Prison population in Kent 	<p>1% reduction per annum smoking prevalence rates</p> <p>Rate of deaths attributable to smoking in all persons aged 35+</p> <p>Mortality from lung cancer directly</p>

	<ul style="list-style-type: none"> - Pregnant women - Families who smoke in areas of deprivation <p>Stop smoking services should aim to treat at least 5% of the local smoking population each year. In Kent, this equates to at least 14,000 smokers</p>	ASR for persons <75*+slope index
6.3 Mental Health		
There is an embedded approach across partners to improve mental well-being that also addresses the broader determinants of mental health and can measure the impact of changes to well being. There can be no health without mental health and those experiencing stigma or discrimination will be supported.		
6.3.1 Promote Improving Access to Psychological Therapies programme (IAPT) to deprived areas	Training for staff and access to new or improved services to help children, young people and adults with depression or anxiety within their own communities.	
6.3.2 Support and promote the Live it Well website and the 5 ways to wellbeing		http://www.liveitwell.org.uk/
6.3.3 Deliver the mental health impact assessment tool in key locations	Mental Wellbeing Impact Assessment (MWIA) enables local service commissioners and community organisations to assess and measure the impact of their interventions on their population's mental health and wellbeing. It will provide an effective approach to creating policy and services that have the best possible impact on mental well-being	
6.3.4 Deliver mental health awareness via healthy living centres in deprived areas		
6.4 Grow partnerships and find new ways to target and deliver services in places where people go (Asset based community development)		
6.4.1 Develop healthy settings: healthy living centres, healthy living pharmacies, local authority well points	Partner organizations including the 3rd sector come together to tackle broad health issues within a community. Such Hubs promote good health and well being by encouraging healthy lifestyle choices and provide tailored support, advice and guidance to tackle local issues, such as debt, family relationships etc	

<p>6.4.2 Use existing opportunities presented by Gateways, schools, libraries, hospitals, district council offices, the 3rd Sector, leisure centres, job centres etc to promote ill health prevention</p>	<p>Partnerships and links are working between different organisations across the public and voluntary sectors, and different departments to deliver access to health services and information in places where people feel comfortable and experience positive interactions with services</p>	
<p>6.4.3 Continue to research and gain understanding of our communities and how best to support them to help target scarce resources</p>	<p>More accurate understanding of prevalence by district has influenced commissioning of targeted services leading a reduction in the social gradient (the gap has narrowed between the health of the richest and the poorest)</p>	

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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
 Meradin Peachey, Director of Public Health

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **Public Health Performance**

Classification: Unrestricted

Summary: This report provides an update of Public Health performance, particularly on the two programmes highlighted specifically in the NHS Operating framework (Health Checks and Stop smoking Services). The report also provides a high level summary of the entire Public Health work programme for Kent.

Introduction

Part of the NHS reforms is the move of Public Health to the local upper tier Local Authority, and the move to the Local Authority of a ring fenced budget for health improvement.

In July 2011, the full Kent County Council approved the Memorandum of Understanding between the County and NHS Eastern and Coastal Kent and West Kent Primary Care Trusts for a change in leadership for Public Health and Health Improvement to the County. The MOU also highlighted the health improvement budget of some £17m, which, subject to national confirmation, is likely to move to KCC in April 2013.

Performance of Health Improvement Programmes

The NHS Operating Framework for 2012/13 was recently published. The Framework emphasized two particular elements (NHS Health Checks and Stop Smoking) of commissioning health improvement which are reported on as a priority here

1. NHS Health Checks

Eastern and Coastal Kent has a target of 26,655 health checks to be offered by Q4, with a rising trajectory plotted across the 4 quarters of the year as demonstrated by figure 1. The expected percent of the year total to have been offered by Q2 is 16.3%. The actual percent of the year total to have been offered by Q2 is 14.3%.

West Kent has a target of 24,575 health checks to be offered by Q4, again with a rising trajectory plotted across the 4 quarters of the year as shown in figure 1. The expected percent of the year total to have been offered by Q2 is 16.3%. The actual percent of the year total to have been offered by Q2 is 2.6%.

Eastern and Coastal Kent is short of Q2 target, but not significantly, we expect this to be pulled up. West Kent however is significantly short of target. Part of this is because it started late, but there is also under activity to date. A recovery plan has been drawn up and is in discussion with the Kent Community Services Trust who is the sub contractor for

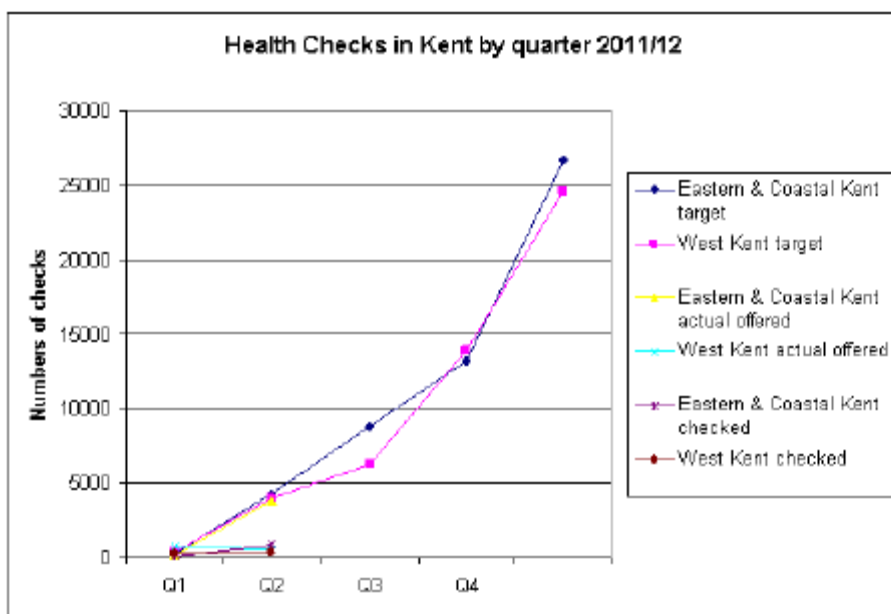


Figure 1 Health Check Trajectory and Progress; Eastern and Coastal Kent and West Kent 2011/12

the service in West Kent. The recovery plan is being shared with the SHA and it will be available for reporting to Kent and Medway Cluster Executive and Board and a future POSC if required.

2. Stop Smoking Services

Both East and West Kent Stop Smoking Services achieved Q1 targets. Q2 targets were submitted to the Department of Health on the 9th December 2011.

Both services submitted returns showing they are on track to attain the annual targets (West Kent 4220 quitters and East Kent 5197 quitters)

Eastern and Coastal Kent Stop Smoking Service

Cumulative quits	Q1 (Apr - Jun)	Q2 (Jul-Sept)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
Plan	1,245	2,397	3,495	5,197
Quits Achieved	1,285	2,545	2,847	

West Kent Stop Smoking Service

Cumulative quits	Q1 (Apr - Jun)	Q2 (Jul-Sept)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
Plan	844	1688	2743	4220
Quits Achieved	946	1720	1778	

Note Q3 is not closed until early March, thus figures for Q3 appear to be low. Q4 at the time of writing had not started.

Both Eastern and Coastal Kent and West Kent services are performing relatively well when benchmarked with other Stop Smoking services across the Southeast SHA area

3. Other Health Improvement programmes

Performance of these programmes was included in the paper presented to the last POSC held in November 2011 alongside the context and outline of each programme.

These will be updated at future POSCs.

Wider Public Health Performance

The attached paper (included in the PCT Cluster Board Performance report) provides a high level summary of the overall range of programmes the Public Health Directorate is working on across Kent in order to promote and protect the health and well being of the population.

Recommendation:-

4. Members are asked to note the performance report of Public Health.

Andrew Scott-Clark
Director of Health Improvement

Background Information: *Nil*

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Staying Healthy

The following is an amended high level summary of the Public Health work programme covering the three areas of Public Health practice published in the Performance section of most recent (November) NHS Kent and Medway Board papers

Key Priorities

- **Health Services** – Supporting Clinical Commissioning Groups (CCGs) in their Public Health responsibilities and Child and Adolescent Mental Health Services (CAMHs) programmes.
- **Health protection** – Childhood & seasonal vaccination, Screening.
- **Health Improvement** – Through the dual developments of Health and Wellbeing Boards & Joint Strategic Needs Assessments devise a health strategy and commission programmes and promote lifestyle modification.

Key work streams

- **Health Services** – Development of Clinical Commissioning Group Public Health support to inequalities & Joint Strategic Needs Assessment focused plans.
- **Health Protection** – Immunisation programmes, antenatal and newborn screening programmes, cancer screening programmes, other screening programmes.
- **Health Improvement** – Promoting physical and mental health and wellbeing, smoking cessation, sexual health, healthy weight, safe alcohol consumption, and avoidance of drug misuse related harm and broad public health advocacy.

Summary of progress to date

- **Health Services** – Kent Clinical Commissioning Group Public Health Support – draft service specification consultation, utilisation review benchmarking programme extending to all acute trusts, National Awareness and Early Diagnosis Initiative (NAEDI) Lung Cancer funding £38k project in progress.
- **Health Protection** – Childhood immunisations coverage good, expanded (EK) support team expected in place by Q4. Initial evidence Health Professional uptake better this year. Cancer Screening programme expansions going to plan.

- **Health Improvement** – Health check programmes continuing to improve, cost pressures likely as predicted, being managed to date. Smoking cessation on targets met, Brief Alcohol advice programme expanded across all community providers, target remains (reducing alcohol-related hospital admissions) challenging. Chlamydia positivity improved. Lab costs renegotiated to deliver savings. Long Acting Reversible Contraception (LARC) programme expanded. Healthy Passport programme expanding, initially DH funded (pump prime), now consolidating through internal resource rearrangement.

Examples of what's changed to benefit patients in 2011/12

- **Health Services** – Local strategic needs assessment – based on Clinical Commissioning Group denominator populations, with health profiles and variations delivered to all CCGs for planning cycle. PH support in interpretation leading to inequalities action plans.
- **Health Protection** – Human papillomavirus (HPV) augmentation of cervical screening for introduction in New Year planning in progress.
- **Health Improvement** – Consolidating alcohol interventions to provide Kent wide coverage.

Assurances

- **Health Services** – Needing to coordinate PH with wider Clinical Commissioning Group development.
- **Health Protection** – Seasonal flu immunisation coverage information being uploaded by month.
- **Health Improvement** – Public Health resource identification exercise further updated.

Risks and Challenges

- NHS Eastern and Coastal Kent Childhood immunisations require continued improvement.
- Health checks NHS Eastern and Coastal Kent challenge to meet stretch target, NHS West Kent cost pressure challenge.
- Resource identification demonstrates challenging under funding in Public Health in West Kent.

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
Meradin Peachey, Director of Public Health

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **Joint Strategic Needs Assessment (JSNA)**

Classification: Unrestricted

Summary Joint Strategic Needs Assessment identifies 'the big picture' in terms of the health and wellbeing needs and inequalities of a local population."

Attached are the Department of Health's latest guidance on JSNAs and joint health and wellbeing strategies and a copy of the Kent JSNA refresh which is work in progress

Introduction

Joint Strategic Needs Assessments (JSNAs) describes a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness.

JSNAs are not a new concept and have been published previously for the benefit of commissioning health improvement and health services. With the transition of the structure of the health service the ambition is for an enhanced role for JSNAs and health and wellbeing strategies to enable Local Councillors, GPs, and Directors of Public Health, Adult and Children's services to work with communities in leading a more effective and responsive local health and care system.

Kent JSNA

Attached is the latest working refreshed draft of the summary Kent JSNA. As Kent covers a large diverse area the JSNA will also reflect more local strategic priorities, both at Clinical Commissioning Group level and at District/Borough level too.

Full detail can be found at the Kent Public Health Observatory website:
<http://www.kmpho.nhs.uk/jsna/>

Recommendation:-

This update is provided for information only. If Members would like further discussions on the JSNA, then the Cabinet Member for Adult Social Care and Public Health would be very happy to convene a cross party group if required

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Background Information:

<http://www.kmpho.nhs.uk/jsna/>



Joint Strategic Needs Assessment and joint health and wellbeing strategies explained

Commissioning for populations

Joint Strategic Needs Assessment and joint health and wellbeing strategies explained – commissioning for populations

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	16731
Title	Joint Strategic Needs Assessments and joint health and wellbeing strategies explained
Author	Department of Health
Publication Date	05 Dec 2011
Target Audience	PCT CEs, NHS Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs, HealthWatch England and Local pathfinders, CCG pathfinders, early implementer HWBs
Circulation List	
Description	This publication is intended to support the NHS, local government and emerging health and wellbeing boards to develop their understanding of the purpose of Joint Strategic Needs Assessments (JSNA) and joint health and wellbeing strategies, and to set out the resources which can be expected from DH and its partners.
Cross Ref	Equity and Excellence: Liberating the NHS
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	Freya Lock Social Care Leadership and Performance 114 Wellington House 133 - 155 Waterloo Road SE1 8UG 2079724237
For Recipient's Use	

Joint Strategic Needs Assessments and joint health and wellbeing strategies explained

Commissioning for populations

Prepared by Social Care, Local Government and Care Partnerships Directorate

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Foreword

Health and wellbeing boards are at the heart of our plans to transform health and care and achieve better population health and wellbeing.

Leaders from across the local community will come together in health and wellbeing boards. They will have a collective focus – to improve services for the whole community so individuals and communities are able to live healthier lives, and have a better experience of the health and care system.



This publication is an important call to action to emerging health and wellbeing boards. It makes the case for starting work now on two core responsibilities for future health and wellbeing boards – preparing joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies.

While statutory guidance is being developed, and will follow in 2012, taking action now means health and wellbeing boards will grasp an important opportunity. The JSNA and joint health and wellbeing strategy are the key to putting localism into action.

Refreshing the JSNA and developing the joint health and wellbeing strategy over the coming months will provide local partners including clinical commissioning groups (CCGs) with a jointly-agreed and locally determined set of priorities on which to base their commissioning plans within the reformed health and care system going forward. Demonstrating the partnership work necessary to make this happen will play an important role in authorising CCGs to take on their crucial role.

The strengthened role of JSNAs and joint health and wellbeing strategies will enable the local health and care system to go further than ever before. For the first time, decisions about health and care will be made on the basis of clinical expertise, evidence from the JSNA, and the valuable input of locally elected councillors and the public, via local HealthWatch and wider engagement with the community. This means decisions about action, investment and disinvestment can be genuinely local, rather than a reflection of national priorities.

But, I am clear that JSNAs won't have such a galvanising effect on their own. It is only the combination of the JSNA, joint health and wellbeing strategy and aligned commissioning plans that have that potential to be transformational in improving health, care and wider services for people in our communities.

Joint Strategic Needs Assessment and joint health and wellbeing strategies explained – commissioning for populations

This document aims to help health and wellbeing boards take positive action now, so individuals and communities feel the difference sooner rather than later. By agreeing a set of local priorities now, health and wellbeing boards can influence local commissioning plans for the future and grasp the opportunity to create local services shaped around the individuals who use them.

A handwritten signature in black ink, appearing to read 'Paul Burstow'. The signature is fluid and cursive, with the first name 'Paul' being larger and more prominent than the last name 'Burstow'.

Paul Burstow, Minister for care Services, Department of Health

Introduction

*Liberating the NHS – Legislative Framework and Next Steps*¹; *Healthy Lives, Healthy People*² and *Capable Communities and Active Citizens*³ set out the government’s ambition for an enhanced role for joint strategic needs assessments (JSNAs). This strengthened role of JSNAs and joint health and wellbeing strategies will enable Local Councillors, GPs and Directors of Public Health, Adult and Children’s services to work with their communities in leading a more effective and responsive local health and care system. They will sit at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community. As such, they are a key to the success of health and wellbeing boards and individual commissioners in the future local health and care system.

JSNAs will be the means by which local leaders work together to understand and agree the needs of all local people, with the joint health and wellbeing strategy setting the priorities for collective action. Taken together they will be the pillars of local decision-making, focussing leaders on the priorities for action and providing the evidence base for decisions about local services. The Government’s ambitions for health and wellbeing clearly envisage clinical commissioning groups (CCGs) and local authorities jointly leading the local health and care system, through health and wellbeing boards and in collaboration with their communities. New relationships between councillors, directors of public health and clinicians will therefore be key to rejuvenating the local approaches to improving the health and wellbeing of their populations.

The JSNA and joint health and wellbeing strategy can be the foundations upon which health and wellbeing boards exercise their shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education. JSNAs and joint health and wellbeing strategies will enable commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes. Health and wellbeing boards will have the opportunity to better engage their communities in their development, thereby empowering local people have a say in shaping the services they use. Service providers, commissioners, district and borough councils and local voluntary and community organisations will all have an important role to play in identifying and acting upon local priorities.

As the transition to the new health and care system takes shape, emerging health and wellbeing boards will want to drive the refreshing of JSNAs and preparation of joint health and

¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

² <http://www.dh.gov.uk/en/PublicHealth/Healthyliveshealthypeople/index.htm>

³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

wellbeing strategies, not only to help the authorisation of their CCG members, and to underpin commissioning plans for 2013-14; but also to give all local partners a set of jointly agreed priorities to work on together in the new health and care system. Through the National Learning Network for health and wellbeing boards (described further on p.14) and the development of resources, we want to support health and wellbeing boards through this transition.

Summary

The purpose of this document is to support emerging health and wellbeing boards as they engage with the refresh of Joint Strategic Needs Assessments and develop their preparatory joint health and wellbeing strategy. It also describes what support the Department of Health will provide, including what resources will be available and when, and how we will build in learning from early implementer health and wellbeing boards in this.

This document should be read as part of the wider approach to supporting the development and implementation of health and wellbeing boards led by early implementer health and wellbeing boards and the National Learning Network for health and wellbeing boards.

The statements in this document are subject to the successful passage of the Health and Social Care Bill through Parliament and reflect the current intentions of the Department of Health in relation to the JSNA and joint health and wellbeing strategy following Royal Assent.

During transition

Although new statutory duties will not take effect until April 2013, activity in the next year of transition will be crucial for the development of the reformed health and care system. It is an opportunity to develop strong relationships, embed new ways of working, build on good practice, and agree priorities for the future before taking full responsibility for the day-to-day running of the system.

Many emerging health and wellbeing boards have already begun to build new relationships in their local areas. We know that many are looking to the future, and capitalising on these new opportunities by involving elected councillors, officers and emerging CCGs supported by their PCTs, and community representatives in reviewing the JSNA and setting a timetable for developing the preparatory joint health and wellbeing strategy. This will have the benefit of providing a local context and collective priorities for the key players in the new system, including CCGs, to develop their commissioning plans from April 2013 when the statutory responsibility passes from the PCT.

Although undertaking these processes will build on existing ways of working, it also signals a break from the past and as health and wellbeing boards emerge, they will be able to develop relationships between those who will be responsible in the future including CCGs, supported by those who currently have responsibility in PCTs.

During the transition period, each emerging clinical commissioning group will seek authorisation through the NHS Commissioning Board. *Towards Authorisation* states that a commissioning plan should be a key source of evidence in authorising CCGs, and the intention is that these will be in line with the relevant preparatory joint health and wellbeing strategies. Of course, collaboration between CCGs and emerging health and wellbeing boards will help CCGs achieve authorisation, but what is crucial is that they develop the JSNA and joint health and wellbeing strategy together, enabling them to commission on the basis of mutual priorities across the broader health and care landscape, not simply from a health perspective.

Beginning the work now, during transition, will give the best possible chance of this.

To ensure a successful approach, emerging health and wellbeing boards will want to develop their local plans with the engagement of the relevant emerging CCGs during 2012. Working under delegated authority from PCT cluster boards, CCGs will want to contribute to a refresh of existing JSNAs that existing partnerships have previously produced and these will inform the first joint health and wellbeing strategies and CCG commissioning plans for their first year of operation. PCT clusters will play an active role in facilitating this transition as well as continuing to provide input on those areas of commissioning which will pass from PCTs to the NHS Commissioning Board in April 2013.

Emerging health and wellbeing boards tell us that during this period they also want to be engaging with their local stakeholders and communities in developing the JSNA and joint health and wellbeing strategy. Many want to develop the relationships and model the collaborative approach that the new system is designed to deliver before it comes into statutory form, thereby hard-wiring it into the way they operate. Identifying key stakeholders now and beginning to build enduring relationships will be critical as will remaining flexible in relation to new changes to the local landscape. Getting the right relationships will be key to unlocking the wider determinants of health such as education, housing, employment and community safety.

Case study - Wigan

Wigan see a real opportunity to transform their approach to achieve better population health, at reduced cost to the public purse, through the development of its Health and Wellbeing Board.

They are trying to address challenging issues: reducing health inequalities, building self-reliance in communities, delivering care closer to home, transforming services to improve outcomes. While significant effort has been put into tackling these issues in the past, the Board has concluded it cannot solve problems by using the same kind of thinking.

For example, previous joint strategic needs assessments (JSNAs) presented a strategic picture of health and disease in Wigan. In 2011, as the shadow Health and Wellbeing Board progressed locally, the JSNA was reshaped to develop an 'asset led' approach. The move from focusing on population problems and 'needs' to assets meant Wigan were able to ask different sorts of questions, such as 'here's what we've got, how can we grow it?'

Wigan also reviewed their activity to address inequalities, and brought in intelligence from a broad range of health indicators, including the social determinants. Wigan put this approach into action in a recent needs and asset assessment on domestic abuse. To ensure that a true picture of need, current delivery, gaps and assets was achieved Wigan engaged with a range of individuals including lead officers, service users, victims, perpetrators, staff and volunteers. This process gathered qualitative intelligence to complement the quantitative data and, amongst other positive outcomes, it identified inequalities in the overall offer that would not have been picked up elsewhere.

In developing its JSNA, Wigan's shadow Health and Wellbeing Board is particularly keen to prioritise the development of intelligence about patients' and the public's experience of services, as well as population health. They are also keen to ensure their JSNA develops in a way that continuously improves the evidence base about what works. This will allow the Board to ensure that commissioning and improvement priorities are implemented in innovative and cost-effective ways.

Once health and wellbeing boards are established on a statutory footing in April 2013, they will take over the statutory responsibility for undertaking the JSNA and joint health and wellbeing strategy. From this point, health and wellbeing boards will want to continue the ongoing process of refreshing the JSNA and developing the joint health and wellbeing strategy ready to feed into the commissioning cycle for 2014-15 and beyond.

The Government sees discussion with local areas as critical during this transition and they will inform this process. Figure 2 below illustrates indicative timings health and wellbeing boards will want to consider as part of their thinking on JSNAs and joint health and wellbeing strategies as they prepare for the new health and care system and to support CCG members in becoming authorised.

	Dec 11	Jan 12	April 12	May 12	July 12	Oct 12	Feb 13	Mar 13	April 13
Health and wellbeing board		Continuous engagement with stakeholders, users and the public	Non-statutory operation						Full statutory responsibility
JSNA	Draft guidance available	JSNA refresh begins or already underway							↑
Joint health and wellbeing strategy	Draft guidance available		Priorities from JSNA needed to inform strategy	Strategy to be developed to feed into commissioning plans					
Clinical commissioning group			Non-statutory operation		Start of authorisation submissions	Authorisation process begins	Commissioning plans to be agreed		Full statutory responsibility Implement agreed commissioning plans
Local Authority planning cycle			Data collection and analysis		Reviewing priorities	Financial planning		Business plan finalised and published	
NHS Commissioning Board	Operating as an SphA focused on business preparation (from October 2011)		Established as an Executive Non-Departmental Public Body with limited statutory responsibility			Partial running as Executive Non-Departmental Public Body			Fully operational with full statutory responsibility

How we will support you

The Government is taking a new approach to implementing change in public services, with innovation and change driven locally to shape services around communities, with the space created by national partners to enable the sharing of work works. You have told us that sharing learning across sectors and between partnerships is vital during this transition, and we will be supporting this nationally and locally.

Statutory guidance and resources

To support the new policy on JSNAs and joint health and wellbeing strategies the Government has committed to producing new guidance on JSNAs and joint health and wellbeing strategies. We have worked with Local Government Association, the NHS Confederation and early implementer health and wellbeing boards to agree how we will take this forward through the National Learning Network for healthy and wellbeing boards (described further on p.14) and plan to:

- develop statutory guidance on JSNAs and joint health and wellbeing strategies, and
- work with partners to develop wider resources to support the development and effective use of JSNAs and joint health and wellbeing strategies.

The statutory guidance, developed with early implementers will build on existing guidance on JSNAs and will cover the joint health and wellbeing strategy, as committed to in the Government response to the NHS Future Forum's recommendations. It will describe the principles of the JSNA and joint health and wellbeing strategy; not specifying form or detailed content, as health and wellbeing boards will determine this locally.

The statutory guidance will be available in draft form in January 2012, but will not be formally published until after the Health and Social Care Bill has gained Royal Assent. However, we recognise that this will not enable health and wellbeing board members, including emerging CCGs to incorporate jointly agreed priorities for action based on identified needs into their planning for April 2013. Hence, the intention that draft guidance will be issued in January 2012.

This draft guidance will be then be further developed with health and wellbeing board early implementers and other voluntary and community stakeholders ahead of publication. From January 2012 we will be engaging with stakeholders on this draft guidance, developed with health and wellbeing board early implementers, and that engagement will then be followed by a short public consultation ahead of the final publication of the final, statutory guidance after Royal Assent. The aim is both to support health and wellbeing boards as they start refreshing the JSNA and developing a preparatory joint health and wellbeing strategy; and also to ensure the final product has taken full account of local circumstances and views, and is fit for purpose.

Our approach to the development and sharing of this guidance aims to be supportive to emerging health and wellbeing boards as they develop their own understanding and discussions on JSNAs and joint health and wellbeing strategies. We also want this process to be an open dialogue with emerging health and wellbeing boards to ensure that the final statutory guidance is fit for purpose and meets their needs by the time they become statutory bodies.

To further support health and wellbeing boards to undertake JSNAs and joint health and wellbeing strategies, and to support stakeholders to engage in the process locally we will work in partnership with sector leaders and interested partners to produce complementary resources. These will build on the statutory guidance and will feature products to explore issues faced by emerging health and wellbeing boards, alongside themes and best practice. These resources are just as important as the statutory guidance – we are taking this different approach to paint a picture of how the JSNA and joint health and wellbeing strategy can work on the ground, informed by those who are actually engaged in them locally.

These products will be shaped and informed by what health and wellbeing board early implementers and wider stakeholders tell us they would find supportive and useful to meet their own needs and interests. These will be available in early 2012, and again emerging health and wellbeing boards will be able to feed into this process through the National Learning Network and through work underway at a sub-national level.

Support for health and wellbeing board implementation

Support for the implementation of health and wellbeing boards has been developed with the Government's new approach in mind. Health and wellbeing boards with truly collaborative leadership and partnership across local services will be key within the new health and care system; therefore, we have taken a lot of care in their development and implementation. Early implementers and stakeholders have been united in a desire for health and wellbeing boards to make a real difference and not just be 'talking shops'. In some places this means using the creation of the health and wellbeing board to drive existing partnership work further. In others, it is an opportunity to do things differently, recognising that existing partnerships are not 'delivering the goods'. The National Learning Network provides an opportunity for health and wellbeing boards to debate and stimulate fresh thinking with their peers, as well as supporting the development of highly effective health and wellbeing boards in each locality.

Work with partners has focused on supporting local authorities, CCGs and other partners to bring their own innovation and expertise to the process of identifying and promoting best practice, to ensure health and wellbeing boards are effective. We have also sought to further stimulate and support this localist approach through sub-national activity led by Deputy Regional Directors for social care, SHAs and sub-national local government networks, where it adds value.

The National Learning Network for health and wellbeing boards

We have set up the National Learning Network for health and wellbeing boards to develop knowledge and behaviours that will enable them to work effectively to deliver their shared purpose. The National Learning Network will support all health and wellbeing boards to develop a clear sense of purpose and shared local priorities, collaborative behaviours and strong relationships; and a focus on outcomes and sustainable improvement for local people; so that the health and wellbeing board is greater than the sum of its parts. With this in mind it has been developed in partnership with and driven by the needs of those who are actually developing their health and wellbeing boards, and to complement wider activities at national, sub-national and local levels.

The National Learning Network is made up of:

- a virtual learning hub, hosted through the Local Government Association Communities of Practice⁴, to enable information sharing, collaboration and networking across all sectors engaged in developing health and wellbeing boards
- national learning sets which will enable health and wellbeing board members to work with their peers across the country on key themes of common interest
- leadership development for elected members, alongside clinical leaders and other local partners, delivered by the Local Government Association building on previous development work with elected councillors
- ensuring that the Learning Network for health and wellbeing boards aligns with development and transition support for CCGs, public health and HealthWatch.

We have already developed some parts of the network, and we are working together to complete the other elements. We intend to be flexible in our approach, responding to the network's feedback and ideas. Government will not be issuing guidance across the board, but only on those areas where health and wellbeing boards early implementers tell us they would like additional support – any such resources will be developed with and shaped by the National Learning Network to ensure that they deliver the support where it is needed.

The National Learning Network builds upon the work of the Local Government Association's Healthy Communities Programme, and they have been a key partner in informing and developing this approach as well as showcasing developments already underway at a local level in *New Partnerships, New Opportunities: a resource to assist setting up and running health and wellbeing boards*⁵.

⁴ <http://www.communities.idea.gov.uk/comm/landing-home.do?id=10113659>

⁵ <http://www.idea.gov.uk/idk/core/page.do?pagelId=31196365>

The context

*Equity and Excellence: Liberating the NHS*⁶ set out a vision of a health and care system that achieves the best outcomes in the world. It outlined a move to a new system, which shifts away from centrally driven targets, and instead focuses on putting patients and the public first, delivering the outcomes that matter most to people, and strengthening accountability and local democratic legitimacy.

The joint local leadership of CCGs and local authorities through the health and wellbeing board will be at the heart of this new health and social care system. Through this forum elected councillors, clinicians, and directors of public health, adults and children's services will have a key role to play in using their expertise to achieve a collective focus on improving outcomes and reducing inequalities. They will enable greater local democratic legitimacy of commissioning decisions, and provide an opportunity for challenge, discussion, and the involvement of local representatives.

The *Health and Social Care Bill*⁷ will require the establishment of health and wellbeing boards on a statutory basis in every upper-tier local authority in England. They will operate in shadow form from April 2012, and take on their statutory functions from April 2013. The process of transition from the current health system to the new arrangements is underway, and many health and wellbeing boards are beginning to operate in shadow form.

To support the development and implementation of health and wellbeing boards at a local level, the NHS Confederation has worked with partners to develop *Operating principles for health and wellbeing boards*⁸. This document intends to help health and wellbeing board members consider how to create effective partnerships across local government and the NHS as they set up and establish their health and wellbeing boards.

Health and wellbeing boards will be the forum for councillors, commissioners and communities work with wider partners to address the determinants of health and reduce health inequalities. This is not just about statutory members of the health and wellbeing board – other partners can help to achieve these aims. For instance, the voluntary and community sector can help access chronically excluded groups, and many emerging health and wellbeing boards are finding innovative ways of engaging the sector.

⁶ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

⁷ <http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm>

⁸ <http://www.nhsconfed.org/Publications/reports/Pages/Operating-principles.aspx>

One of the key benefits of establishing health and wellbeing boards will be to increase the influence of local people in shaping services by involving democratically elected councillors and through local HealthWatch, so that services can better meet local need, improve the experience of service users, and improve the outcomes for individuals and communities.

Case study - Harrow

One of the key principles for the development of the shadow Health and Wellbeing Board in Harrow is a focus on user outcomes and engagement.

Over 100 stakeholders and patients joined in an engagement event to begin a discussion on issues and themes Harrow's refreshed joint strategic needs assessment (JSNA). The event gave the emerging health and wellbeing board clear feedback on what the community saw as priorities for a renewed JSNA and highlighted the perspectives of the wide variety of stakeholders in the local health and care system.

In holding the event, Harrow was also able to gain insight into how best to engage with the public and local stakeholder groups. Using the feedback they gathered Harrow are now producing a pan-Harrow engagement plan. The plan will help the Board to have a genuine dialogue with local citizens and groups, hear the issues they raise and respond. As a result of what they heard at the event, they are also developing a new webpage and newsletter to keep people informed,

Over the coming months Harrow plan to:

- make an impact on the 3 priorities of older people, most excluded families; and health and worklessness
- continue to develop the Board
- refresh the JSNA by March 2012
- develop their Joint health and wellbeing strategy for September 2012.

These changes are happening against a backdrop of whole system change, as clinical commissioning groups, the NHS Commissioning Board, HealthWatch and the transition of public health to local government take shape. Where successful JSNAs exist, the successful relationships underpinning them will offer continuity and focus through this transition. In areas where new arrangements need to emerge, a focus on the JSNA and joint health and wellbeing strategy through the health and wellbeing board will provide a focus that can help to identify common goals and ambitions.

Case study - Buckinghamshire

Buckinghamshire are in the process of developing their joint health and wellbeing strategy. The emerging health and wellbeing board is clear that it has responsibility for improving the health and wellbeing of all residents, from the 'cradle to the grave'; and has agreed four overarching outcomes:

- every child has the best start in life
- everyone takes greater responsibility for their health and wellbeing
- everyone is treated fairly and has the opportunity to fulfil their potential
- keeping people healthier for longer - add years to life and life to years.

Buckinghamshire took a number of factors into account in to arrive at these outcomes, including:

- information on existing priorities from other strategies in Buckinghamshire; including the existing joint strategic needs assessment
- professional and personal experiences from board members
- taking a positive approach to outcomes, but building in an emphasis that residents must take some responsibility for their own health
- using plain English and being recognisable to residents
- good practice examples of other joint health and wellbeing strategies were also used to inform the discussions.

Over the next few months, the board will begin to refine the priorities within each outcome, prior to a public consultation on the strategy. They are keen that the priorities to be included in the consultation should not duplicate areas of work being carried out by others. In future meetings the board will consider where it can add value, where a different or innovative approach may be required and where the inequalities 'gap' can be reduced most effectively

The development of a new JSNA will be discussed in early 2012 and will be used to inform the joint health and wellbeing strategy in 2013 when the board becomes a statutory body.

The JSNA and joint health and wellbeing strategy are crucial enablers of the new system, important for commissioners, providers, service users and the wider community.

The Joint Strategic Needs Assessment and joint health and wellbeing strategy

Building on existing foundations

The JSNA was introduced to create stronger partnerships between communities, local government and the NHS, providing a firm foundation for commissioning that improves health and social care provision and reduces health inequalities. It was intended to help commissioners shape services to address local needs, and a number of supportive resources have been produced to help local areas undertake their JSNAs.

Local areas have told us that since they were introduced in 2008, the best JSNAs have been those undertaken through strong and collaborative partnerships at all levels, who recognise the opportunity and share the responsibility to improve health and wellbeing across all local services; using this to drive innovation and new ways of working. **The health and wellbeing board provides an opportunity to build upon this good practice in taking existing JSNAs further so enabling the transformation of services through collaborative leadership and the development of a joint health and wellbeing strategy.**

In the new system, responsibility for undertaking the JSNA and joint health and wellbeing strategy will come through the health and wellbeing board, and elected councillors, directors of public health and clinicians will have critical roles to play. They will be a vital tool to support health and wellbeing boards to understand the needs of their whole community, and agree collective action to address those needs. By bringing together insights from communities with a range of high quality evidence and information, which could include other local assessments and non-health data, the health and wellbeing board can make collaborative decisions on how best to meet those needs, through joined up, integrated and appropriate services and by tackling the wider determinants of health. They will, enable users and the public to understand the factors that influence services in their area and have input into shaping those services.

Health and wellbeing boards will provide local strategic and collaborative leadership in the reformed health system. As such they are the natural home for the JSNA as a tool to support the local service leaders to take a strategic view of the needs and assets in their areas and use this knowledge to inform service planning. CCGs will commission the majority of services, with the NHS Commissioning Board directly commissioning the remainder of services, which will also be supported by the evidence in the JSNA.

From April 2013, the local authority and the clinical commissioning groups, together with local HealthWatch, will be required to prepare the JSNA through the health and wellbeing board, undertaking a comprehensive analysis of the current and future needs and assets of their area. In the context of the JSNA an asset could be anything that can be used to improve outcomes and impact on the wider determinants of health. This could be facilities such as a One Stop Shop, or green spaces; but also local businesses, local providers with a specific expertise, or capacity within the local community, such as lunch clubs for isolated older people. This includes needs and assets relevant to health, social care and public health across the full lifecourse, covering children, young people and adults; and involves an analysis of the wider determinants of health.

By looking at these assets health and wellbeing boards can explore what other resources are available to them by working with partners to meet local needs and achieve shared priorities. This could create innovative solutions to issues or create opportunities for wider community involvement. For instance, links to a Local Enterprise Partnership could be used to encourage and support people back into work as a way improving their health and wellbeing as well as supporting the local economy.

Based on the JSNA, the members of the health and wellbeing board will then develop a joint health and wellbeing strategy for their area. This joint strategy should support health and wellbeing board members to take the important step from assessing needs and available assets to planning the delivery of integrated local services based upon those needs and assets, and collectively addressing the underlying determinants of health and wellbeing. **In this way the JSNA and joint health and wellbeing strategy combined form the basis for local decisions that drive service change such as investment and disinvestment in services according to local needs and engagement with the local community.**

The joint health and wellbeing strategy is intended to inform commissioning decisions across local services such that they are focussed on the needs of service users and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Likewise, the joint health and wellbeing strategy will also need to take account of the NHS Commissioning Board's Mandate from the Secretary of State for Health. Coherence and understanding of local commissioning arrangements across partners will ensure that vulnerable groups are not overlooked. The joint health and wellbeing strategy can also be used to influence the commissioning of local services beyond health and care to make a real impact upon the wider determinants of health.

The joint health and wellbeing strategy drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement of their own health and wellbeing. Local authorities, CCGs and the NHS Commissioning Board will need to have regard to local JSNAs and joint health and wellbeing strategies as they draw up their commissioning plans so that their plans are fully aligned with their jointly agreed priorities.

The joint health and wellbeing strategy is a unique opportunity for the health and wellbeing board members to explore together the local issues that they have not managed to tackle on their own. The JSNA and joint health and wellbeing strategy allow the health and wellbeing board to analyse the wider perspective of wellbeing, helping local partners on the health and wellbeing board reach a consensus on the priorities to be addressed across the system, and how to make best use of collective resources to achieve them. No single organisation can do this alone, but a shared sense of priorities, built on confidence and trust and supported by a robust evidence base, can help partners work together and focus in on key issues that really matter locally.

A focus on outcomes

In assessing needs and priorities, the health and wellbeing board should adopt an ‘outcomes-based approach’, considering how their work can focus on improving the outcomes that matter most to their populations. Through the joint health and wellbeing strategy they will set the local priorities for joint action. They will be able to use information and indicators from the national outcomes frameworks for the NHS, Adult Social Care, Public Health (and at clinical commissioning group level, the Commissioning Outcomes Framework) to assess current outcomes to inform their JSNA, and identify desired outcomes to drive their joint health and wellbeing strategy. The health and wellbeing board could be the place where the national outcomes frameworks come together, supporting a primary focus on local priorities.

The collaborative nature of health and wellbeing boards will go beyond a joint assessment of needs and priorities as these are not ends in themselves. The health and wellbeing board will also be involved in the development of commissioning plans of constituent health and wellbeing board members. This opens up opportunities for the collaborative design and evaluation of commissioning intentions between health and wellbeing board members to look together at the congruence of commissioning priorities with objective information from the JSNA.

Commissioners will be required to consider the Health Act flexibilitiesⁱ for joint working, such as pooled budgets; which has the potential to further enhance the partnership aspect of health and wellbeing boards based on evidence from the JSNA and priorities from the joint health and wellbeing strategy. The membership of the health and wellbeing board also provides an opportunity to look across the NHS, Adult Social Care, and Public Health Outcomes Frameworks as a piece, to agree and express their priorities and outcomes as a locality, across all these areas.

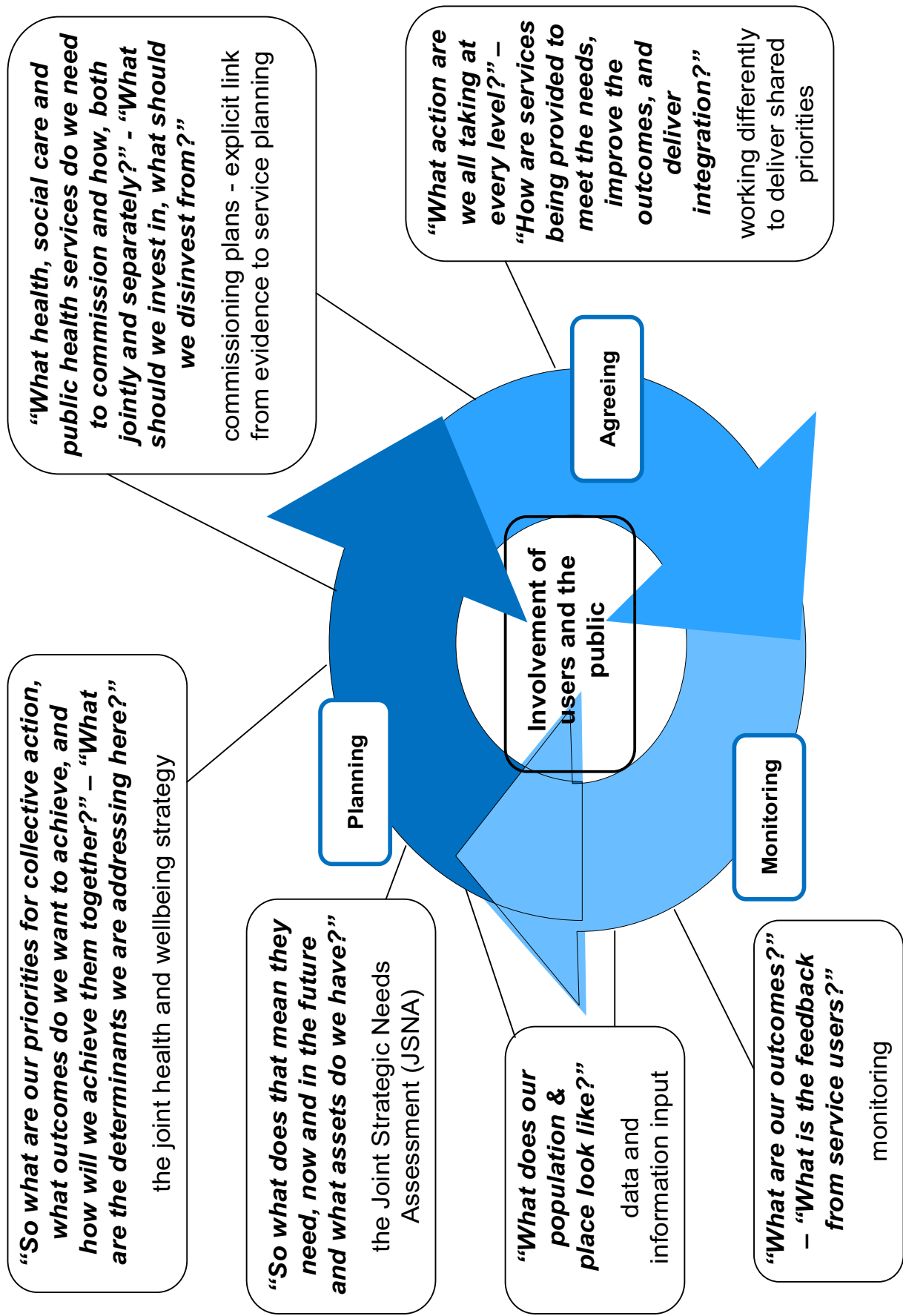


Figure 1: How the commissioning cycle and JSNA and joint health and wellbeing strategy fit together

Promoting integration

There are increasing numbers of people living with multiple long-term conditions, and as such improved integration across services is now a priority. There are many aspects of the health and care modernisation programme which promote integration, and health and wellbeing boards will be key to this agenda locally.

The NHS Future Forum and the Social Care engagement exercise, *Caring for our future*⁹, are both exploring how to integrate the delivery of services; what the barriers and potential incentives are on the ground; which services should be more integrated around users; and how integration can achieve better value for money. Collectively this work will not only inform Government and the modernised health and care system; but will also provide potential solutions and best practice from across the NHS and local government.

Health and wellbeing boards and CCGs will have a duty to encourage integrated working of commissioners and providers in order to improve the health and wellbeing of the local population, reduce inequalities, and improve the quality and experience of services for the local population. They have the opportunity to do this not only at a strategic level, but also to establish this approach with wider partners at a local level.

These benefits are not merely for the local system and organisations however; they will improve the quality of services, and experiences and outcomes for service users, their families and carers in accessing services centred around them. In a period of both economic and demographic pressure, this alignment of service planning and provision could also be of great benefit to the taxpayer, with the opportunity for more efficient use of shared resources.

In the transition of public health functions to local government the director of public health will be able to use their membership of the health and wellbeing board to act as a lynchpin between local health and local authority services. This will ensure better integration between public health and services such as housing and education that have considerable impact on the wider determinants of health.

Providing support to directors of public health and teams across local authorities will be a new national organisation, Public Health England (PHE). PHE will be responsible for the provision of integrated advice and services to protect the health of the people of England from new and existing health threats, and to promote their health and wellbeing. The organisations that will make up PHE - including the Health Protection Agency, the public health observatories and the cancer registries, among others - will continue to provide information and intelligence support to the development of JSNAs. This will be both at a national level, by ensuring that public health data is readily available, and at a local level through the provision of expert localised advice and support to understanding and interpreting this information.

⁹ <http://caringforourfuture.dh.gov.uk/>

In undertaking the JSNA and joint health and wellbeing strategy, boards will also have the opportunity to align with other parts of the local system that impact upon health, care and the wider determinants of health. As part of this, health and wellbeing boards can consider joint commissioning opportunities with other local bodies, thereby enabling joined-up interventions and alignment of resources in tackling issues that will benefit from multi-agency working, for example, tackling worklessness, reducing crime and re-offending, improving housing quality, or child and adult safeguarding. Such local alignments will help the health and wellbeing board to take an overview over how the determinants of health affect their local populations and how they could be better addressed across the spectrum of local services. Some of these relationships and partnerships may already exist in some areas, but some health and wellbeing boards will wish to build upon these or establish improved ways of working. These relationships can be mutually beneficial for local services, and the health and wellbeing board may help local partners to achieve their own aims through joint working. For instance, initiatives to support ex-offenders into the workplace will have a positive impact on their health and wellbeing (and possibly wider determinants of health, such as housing status), whilst stimulating the local economy and reducing their chances of re-offending.

Engaging the public

The health and wellbeing board will have a duty to involve users and the public in the development of both the JSNA and the joint health and wellbeing strategy, and pay due regard to the Public Sector Equality Duty. This will strengthen local accountability, enabling health and wellbeing boards to work with the local community and partners to identify needs and assets, and to jointly decide and agree actions to address them and utilise their potential. Through this involvement, the local community will have the ability to influence local services and have an understanding of what other factors have influenced service provision in their area. There is an opportunity here for greater partnership with local stakeholders and the community, through which local assets and resources can be offered and used as a way to work together to address local needs and tackle the wider determinants of health in a different way.

This will not be the only opportunity for the public to shape their services, as CCGs and the NHS Commissioning Board will also be required to involve the public and service users in the planning of services or service change, as local authorities already do. Health and wellbeing boards might consider how other local partners engage with the public and identify opportunities for alignment and rationalisation.

The JSNA and joint health and wellbeing strategy will therefore be of interest not just to health and wellbeing boards, the local health and care system commissioners and providers; but also to the users of services, their families and carers; and the wider community. JSNAs and joint health and wellbeing strategies which are open and accessible to all will be able to facilitate and assist the engagement of a variety of audiences with differing needs, and will be of use to them all to drive the direction of the local system as intended by the wider health and care reforms, **bringing decision making about services closer to users and the public.**

Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations

For further information please email JSNAandJHWS@dh.gsi.gov.uk

ⁱ NHS Act 2006, section 75.

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Joint Strategic Needs Assessment

Executive Summary 2011

Version 5a

Background

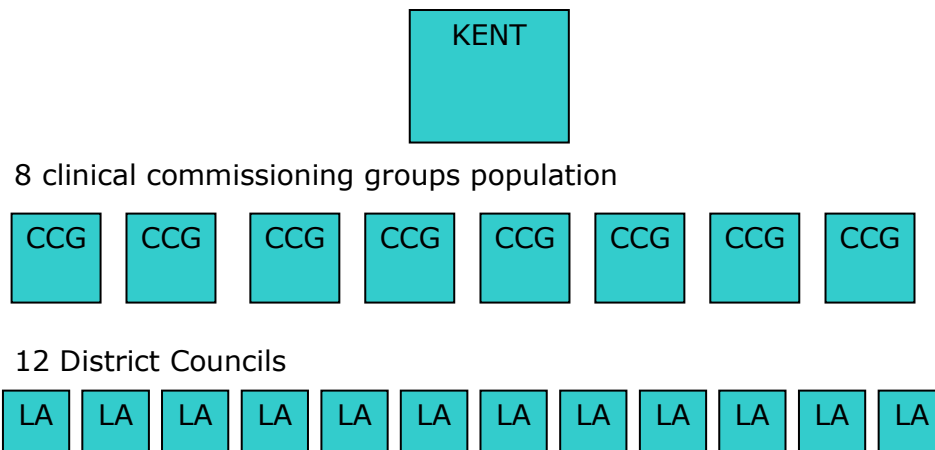
1. JSNA is an ongoing process a range of data, information and analysis about the health and wellbeing of Kent is collated, assessed and compared in order to present an understanding of the all the issues impacting on the population of Kent. Through this process we can gain a high level understanding of the inequalities and needs that exist within.
2. The JSNA is not a strategy and does not in itself offer any answers to the issues it presents. It provides some key priorities and makes recommendations on how action to address these should be taken forward.
3. It has the following purpose
 - To coordinate strategic direction, effort and resource commitment of the range of public, private and voluntary/community sector organisations that work to the common goals of improving health and well being for the population of Kent.
 - To ensure that resources are focused on achieving maximum impact on improving the health and wellbeing of the people of Kent specifically targeting those who are in greatest need.
 - To maintain a focus on health improvement and prevention and ensuring efficient use of available resources.
 - To provide evidence of cost effectiveness and value for money

The Health and Wellbeing Strategy will provide the strategic direction for Kent.

Kent Approach

Kent is a two Tier County Authority, with 12 District Councils and 8 emerging Clinical Commissioning groups.

The JSNA needs to be relevant to a number of difference audiences to ensure a joined up approach to reducing health inequalities and address the Health and Social Care Needs of the population of Kent. Priorities and recommendations made at a Kent level should be relevant to both District Councils and Clinical Commissioning Groups.



1.2 Phase 1 – Reviewing where we are.

Kent has traditionally produced two JSNA documents, one for Adults and one for Children. The Adults JSNA was refreshed in July 2011 and the Children’s update will be published in December 2011. These provide high level recommendations for improving the Health and Wellbeing of Kent.

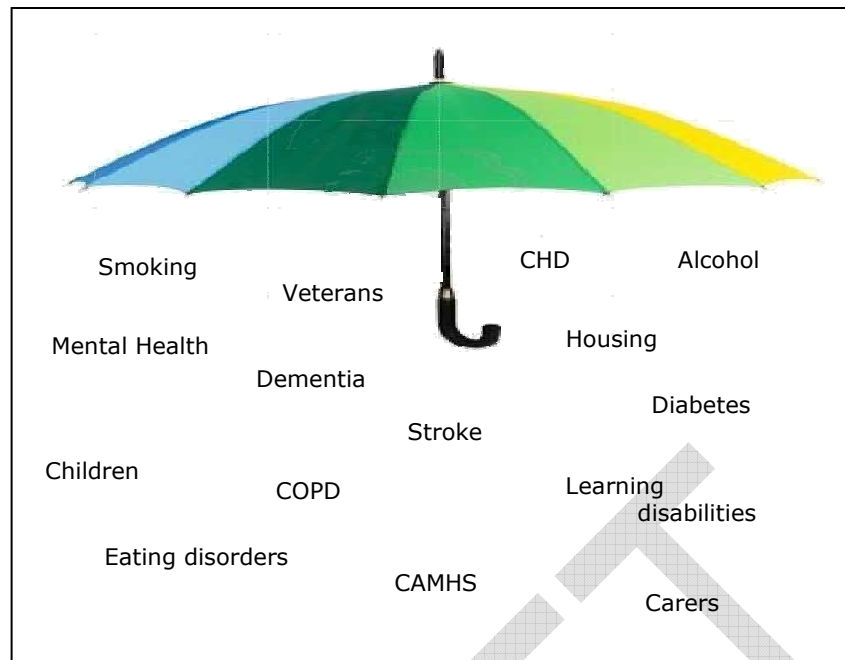
The JSNA can be seen as an umbrella under which other health needs assessment are produced to answer gaps in knowledge and understanding.

The approach during 2011 has been different to previous years. Within Kent Health Needs Analysis are undertaken for specific conditions or for specific population groups. These contain a wealth of information and recommendations for action to reduce inequity in provision of services and to reduce inequalities within the Kent population.

In excess of 40 needs assessments have been undertaken across Kent, exploring in-depth the health needs of the population of Kent, gaps in service provision and levels of un-met need. For each of these needs assessments an executive summary has been produced detailing the key issues in a structured format. These are available from the Kent and Medway Public Health Observatory Website www.kmpho.nhs.uk/jsna, these summaries along with key population indicators presented in the Health and Social Care Maps and locally developed Clinical Commissioning Group profiles provide the basis for the Kent JSNA.

Figure X details some of the needs assessments that have been recently undertaken.

Figure X: **The JSNA is an Umbrella of Needs Assessments**



The JSNA refresh focussed on **Quality Innovation Productivity and Prevention (QIPP)**. The current economic situation requires NHS in Kent and Medway to deliver improved quality of care and productivity as per the Next Stage Review (NSR) Vision over the next five years. The total projected funding gap is £686m across K&M over the next five years (£270m in West Kent, £303m in East Kent) and with expected increases in both cost base and demand from our population.

- Three areas of savings have been identified:
 - Service improvement initiatives. e.g. pathway optimisation, to drive efficiency through commissioning expenditure
 - Commissioning lever initiatives to drive up quality and productivity gains e.g. through utilising to full effect contract levers and system management opportunities, PbR tariffs and primary care contracting
 - Transformational change initiatives at the whole system level e.g. prevention, self care, care closer to home, to deliver more effective and efficient services

1.3 Phase 2

To develop a series of products that present the JSNA to a number of audiences at a level of granularity that is relevant to them. To ensure that we have the right products for our customers' consultation with Key stakeholders will need to take place, Appendix B is an example of a profile for Ashford.

Biggest issues for Kent

Through consolidating and reviewing the needs assessment and assessing the indicators there are a number of key themes that are relevant to Kent.

1. The aging population

It is well understood that the population of Kent in the older age groups 64+ and 85+ are predicted to increase over the next 5 and 10 years. The biggest challenges include a larger proportion of the population living with long term conditions, increase levels of dementia and the pressure on health and social care services this increase need will bring.

2. Sustainability

3. Prevention

Reducing modifiable risk factors – smoking, levels of obesity, alcohol consumption, increasing level of physical activity

4. Economic climate

Access to good quality employment, more people are likely to become unemployed over the next two years impact of unemployment on mental health

Recovery

Impact on 18-24s out of work on future health outcomes

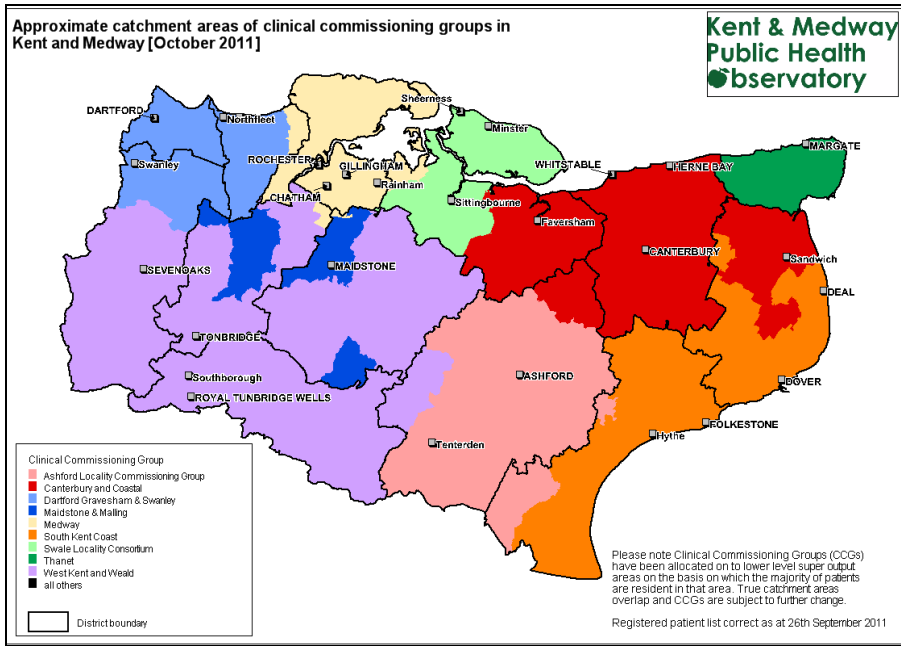
5.

1.4 Kent

As a County Kent generally has better health and social care outcomes than England. However there is significant variation across the districts. Thanet and Swale consistently have poorer outcomes similar to other coastal towns.

Kent expands from the coast to the boundary of London and shares its borders with Surrey and Sussex. There are 12 districts within Kent and 8 emerging Clinical Commissioning Groups (CCG), whose boundaries, as the following map shows are not co-terminus with districts. Kent CC is responsible for approximately 1.5 million people.

Figure X: Approximate catchment areas of clinical commissioning groups in Kent.

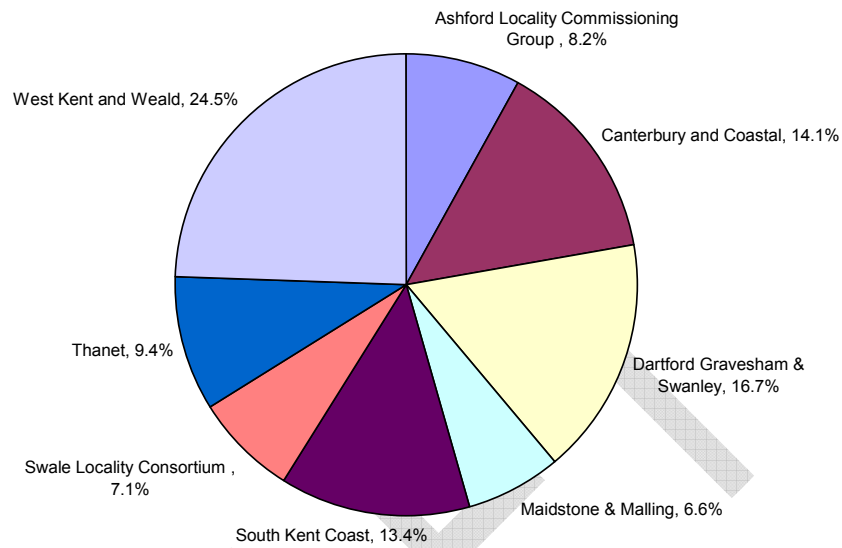


West Kent and Weald is the largest of all the Kent CCGs responsible for a quarter of the total Kent registered practice population. The smallest is Maidstone and Malling consisting of 11 general practices responsible for 6.6% of the Kent registered practice population.

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Figure X: Percentage of Kent registered practice population by clinical commissioning group as at September 2011

Percentage of Kent registered practice population within each CCG as at September 2011



The population is projected to increase by XX% over the next five years and by XX% in 2021. The biggest increase will be in the population aged 65 or older

Insert populations projection chart

Coastal Towns

Seaside resorts are uniquely exposed to many interactive forces including:

- Human forces – bringing in both the elderly and transient whilst luring the indigenous young out of the area whilst keeping holiday makers away;
- Economic forces – maintaining seasonality, polarising housing markets;
- Social forces – contributing to transience, low pay and worklessness;
- Cultural forces – defining the ‘personality’ and meaning of resorts;
- Forces of inertia – that can maintain the status quo of decline.

Table 1 - Key issues for public health and regeneration in coastal resorts

Key coastal issue	Relevance to public health and regeneration
Alcohol	Recent gains made by the NHS through clinical improvements in interventions for cancers and heart disease have been almost cancelled out by the continuing steep rise in alcohol related morbidity

	and mortality over the past five to 10 years. This reflects increases in alcohol consumption across the whole population and is driven by increased availability and reduced cost of alcohol relative to disposable income. Economic regeneration policies focused on alcohol and the night time economy are a major driver (Regeneris Consulting 2007).
In-migration of older people/demographic change	Can create additional pressures on social care and NHS services. Poor mental health, e.g. older people becoming isolated and requiring support following bereavement. Prevention agenda becomes key: this may require regeneration policies to provide relevant opportunities/services.
Houses in multiple occupation	HMOs may attract vulnerable groups or those already receiving benefits, requiring specific support and long term collaborative planning that reduces. HMOs numbers overall and supports homeless and vulnerably housed.
Opportunities for young people	Limited opportunities may lead to low self-esteem, poor mental health, harmful behaviours and difficulties in providing a stable workforce.

Health inequalities indicators

There are four main indicators used to assess health inequalities within Kent and Medway, these are

- life expectancy from birth
- all age all cause mortality
- cancer mortality under 75s
- circulatory disease under 75s

Table X presents a summary of how well each of the districts are doing in closing the gap between those populations within the most deprived 20% and the least deprived 20%. 6 of the 12 Kent districts have closed the gap in life expectancy, the biggest contributor to increasing health inequalities would appear to be deaths from circulatory conditions.

District	Health inequality indicators				Proportion of population	
	Life Expectancy	All age all cause mortality	Cancer under 75	Circulatory disease under 75	Most deprived	Least deprived
Ashford	No	Yes	Yes	No	13%	27%
Canterbury	No	No	No	No	13%	9%
Dartford	Yes	No	No	No	17%	24%
Dover	Yes	No	Yes	Yes	21%	7%
Gravesham	No	No	Yes	Yes	29%	17%
Maidstone	No	No	Yes	No	10%	37%
Sevenoaks	Yes	Yes	Yes	No	6%	42%

Shepway	No	No	No	Yes	29%	8%
Swale	Yes	Yes	Yes	No	31%	5%
Thanet	No	No	No	Yes	42%	2%
Tonbridge and Malling	Yes	No	y	Yes	4%	44%
Tunbridge wells	Yes	Yes	No	Yes	4%	32%
Kent and Medway	No	No	Yes	No		
Medway	Yes	Yes	Yes	Yes	28%	15%

Adapted from Trends in Health Inequalities 2010, Jonathan Sexton and Julian Barlow

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2 Executive Summary

2.1 Important demographic issues

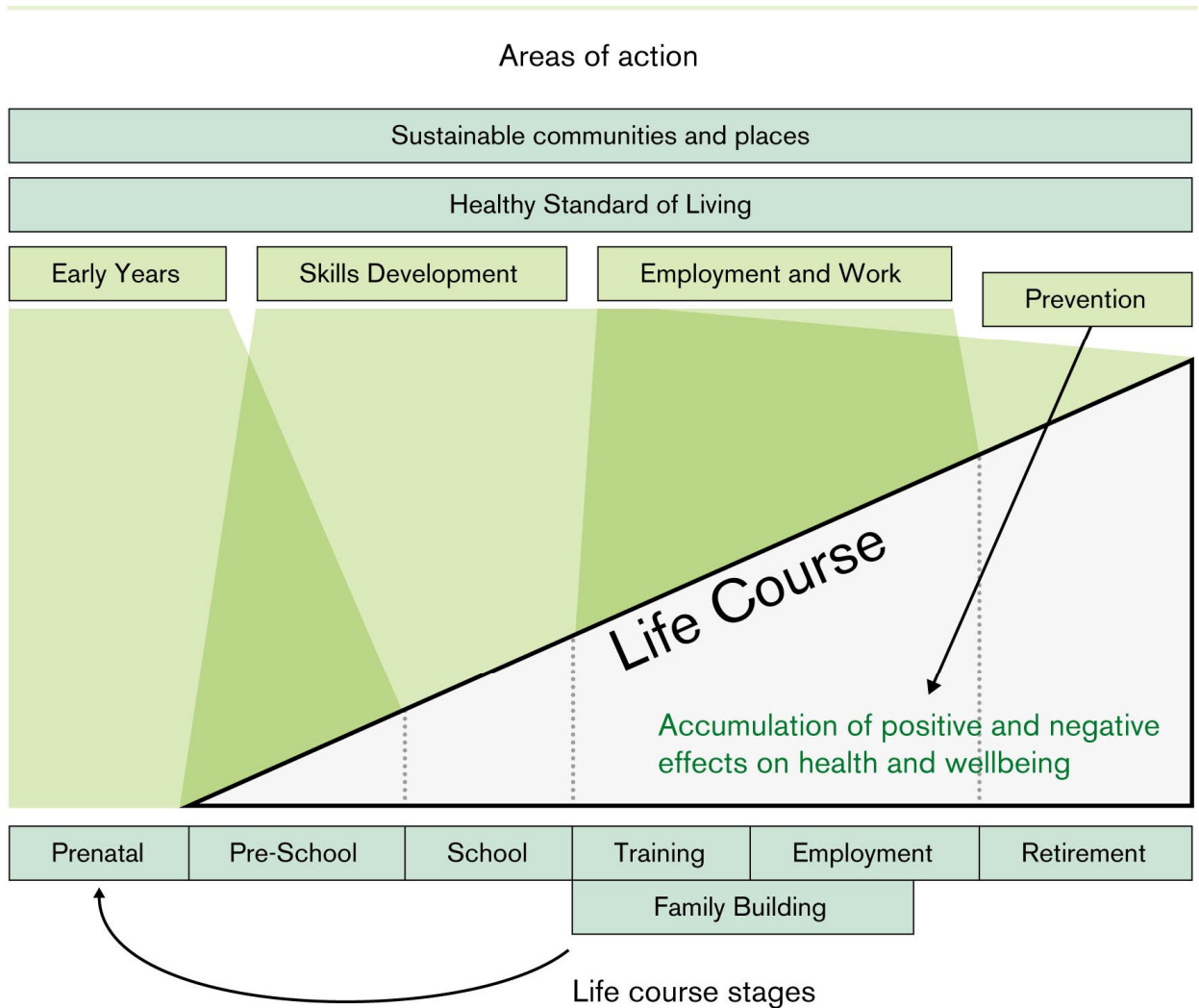
- The biggest population growth will be in the 65+ age group which is predicted to increase by 9.7% between 2012 and 2016 in Kent. There is significant variation across the districts ranging from a predicted population growth in the 65+ age group of 7.4% in Gravesham to 11.8% in Swale. However, there is the 0-4 age group is projected to grow very little in Kent ie. 0.1%. A predicted decrease in this group is predicted in Tunbridge Wells by 4.5% whereas growth in Dartford and Gravesham by 4.3% & 2.9% respectively.
- Parts of Kent are more ethnically diverse than others. The population of Kent was 94% white British in 2001 at the time of the last census. The Office of National Statistics estimates that in 2009 the population was 90.5% white British, with a relatively even growth across the other ethnic groups, including whites of non-British/non-Irish background. Local knowledge suggests that there has been an increase in populations from Eastern European countries such as Poland, data from the 2011 census will enable more discreet profiling of these communities. Gravesham district has the largest communities of BME groups approximately 13%, 7.1% from Asian communities.
- Latest QOF data indicates Swale, Shepway, Thanet and Dover districts having some of the highest prevalence for long term conditions.
- Kent County has better health outcomes when compared to England. However there is variation at district level with Dartford, Dover, Swale and Thanet consistently have higher all age all cause mortality rates than the other Kent Districts.
- The districts mentioned above experience some of the highest levels of deprivation and unemployment, within Kent. The greatest levels of unemployment are in the Thanet District with a rate of 5.8 compared to a rate of 3.9 for Great Britain.

2.2 Health Inequalities

The Strategic Review of health Inequalities in England post 2010 ([Marmot - Fairer Lives Healthy Society](#)) starts with the wider determinants of health, stating that health is an interaction of what we are born with (our genetics), our lifestyle choices, the social and physical environments in which we live and health care services.

The diagram below describes health inequalities across a person's life course from cradle to grave. Marmot specifies 6 key areas where work needs to be undertaken to reduce health inequalities

1. Give every child the best start in life
2. Enable all children and young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop health and sustainable place and communities
6. Strengthen the role and impact of ill health prevention



- Poverty exists all over Kent and Medway and is not confined to specific areas. Nevertheless there are major concentrations of deprivation in the boroughs of Dartford and Gravesham and throughout the coastal east of the county, interspersed with some localised areas of high affluence. The more consistently affluent parts of the county are to be found in Maidstone and the south west quarter of Kent.
- There has been an improvement in life expectancy for the intermediate quintiles of deprivation from 2000 – 2007. However for the most deprived, a pattern of divergence (a widening health gap) has continued throughout this period.

- Analysis indicates that circulatory diseases contributes more towards life expectancy gaps across all district authorities compared to other long term conditions and diseases.
- The overall mortality gap between the richest and poorest in Kent and Medway is increasing over time with quintiles two to five converging upon each other but the most deprived quintile becoming increasingly orphaned.
- The framework also proposes that these influences accumulate across our lives. Some influences are protective and others present risks. Where risk outweighs protective factors, chronic disease, disability and mortality begin manifesting from around age 50.
- Latest results published in 2011 indicate that for 5 out of 10 social determinant and health outcome indicators, Kent County performed significantly better than the England average such as, male and female life expectancy, child development at age 5, young people in education, employment or training and households in receipt of benefits however this masks major disparities across the County. The remaining 5 indicators were not significantly different from the England average.
- That cancer survival rates have improved and that survival rate has improved more for the lowest socio-economic groups. This is a product of the National Cancer Plan and the improvements to cancer services in Kent.
- Heart disease, respiratory disease and all age all cause mortality has improved for all socio-economic groups across Kent. However the rates of improvement are differential and the greatest improvements are in the most prosperous and middle range quintiles of the Kent population. Whilst there have been notable improvements in rates for the poorest, these have not been as notable as for the majority of Kent's population. Accordingly for these conditions, the health inequalities gap has continued to widen over the period 1999-2001 to 2008-10.

Recommendation

- To map where inequalities has improved in Kent and the possible contributing factors
- To map where inequalities has not improved and the contributing factors and action needed
- To map performance in Kent against the Marmot life course approach
- A paper is being prepared for discussion at the Kent County Council January 2012

2.3 Lifestyles

2.3.1 Smoking

- In Kent, approximately 10,000 admissions each year are attributed to smoking £10 million and £12 million in West and East Kent respectively. A further £860,000 and £1.3 million are also attributed to annual outpatient costs.
- The national prevalence of smoking among adults dropped from 24% in 2005 to 21% in 2008. Smoking prevalence in Kent was higher than the national figure at 24.9% (or 281,300 in 2009), varying from 16% in Sevenoaks and 26.3% in Dartford. However this is expected to reduce in future in line with the downward trend nationally.
- However, the above are based on national synthetic estimates, so there is a need for more local data either through surveys or through an augmentation of the Annual Health Survey for England.
- The Stop Smoking service currently treats 2.2% of the local smoking population. This needs to increase to 5% or 14,000 smokers.

Recommendation

Further emphasis is required to concentrate on vulnerable and at risk groups such young people (especially 20-24 yrs old where prevalence is as high as 32%), pregnancy, mental health and prisoners. This will reduce NHS acute sector costs and long term conditions costs to health and social care.

2.3.2 Physical Activity, Diet and Obesity

- The annual estimated cost of treating diseases related to obesity across Kent was £187.7 million in 2007 and £203.3 million in 2010. This will rise to £233.5 million in 2015 if unchecked.
- There is an obvious strong correlation of social factors such as deprivation with lack of physical activity and poor diets leading to overweight and obesity.
- Recent data suggests areas with higher levels of deprivation such as Swale, Thanet, Dover and Dartford appear to have less physical activity levels than those in more affluent areas. Overall, Kent appears to have slightly lower physical activity levels than the rest of England (10% vs 11%)
- Similar trends are seen for obesity levels, where 25-30% of adult population in the same areas mentioned above, are obese compared to 20-25% in more affluent areas such as Tunbridge Wells. If those who are overweight are included, this makes up approximately 50% of the total adult population in Kent.
- The effects of obesity are considerable ranging from heart disease, diabetes, osteoarthritis and cancer, where high levels of unmet need pose a considerable burden on health care services.

Recommendation

A life course approach (as suggested by Marmot) incorporated within an integrated service model to healthy weight achievement and maintenance is imperative for success, spanning from antenatal programmes, breastfeeding, early years, healthy schools, to Change 4 Life, adult weight management and Tier 3 to 4 specialist services.

In this regard, Kent is developing the service model offering four tiers of service which range from a population approach to maintaining and achieving a Health Weight to surgical procedures to achieve dramatic weight loss for those patients with higher BMI's.

Consider the behavioural model on the healthy weight pathway.

2.3.4 Alcohol & Substance misuse

- It is estimated that excessive drinking accounts for 9.2% of disability-adjusted life years worldwide with only smoking and high blood pressure as higher risk factors. Alcohol related liver disease is now the 5th largest cause of death in the UK.
- The rates of all alcohol-related age standardised admissions is predicted to rise further in Kent this is in line with national trends.
- There were 12,082 admissions to hospital through A&E for alcohol-related conditions in 2007-08 compared with 5,713 in 2002-03.
- The rates of drug misuse related admissions have fluctuated over the last 5 years roughly equating to 210 admissions per year in Kent.
- National guidance estimates that for every £6 spent on implementing identification and brief advice on alcohol harm reduction, could return savings to the NHS of £10 over four years.
- Recent analysis suggests that despite the large increase in numbers in treatment, there are an estimated 1,786 treatment Problem Drug Users who have not been in contact with structured treatment in the past two years.
- Alcohol is also the most commonly used substance among dual diagnosis clients with a substance misuse problems. Half of substance misuse service users are estimated to have mental health needs; this would equate to 982 people in 2010-2011 in alcohol structured treatment (dependent drinkers alone).
- A recent survey on young people's attitudes and behaviours indicated that a small proportion of underage drinking, smoking and substance misuse still exists in Kent stressing the need for further action is still needed such as strict enforcement of banning the sale of tobacco products to under 18s.
- Good, responsive services on referral will encourage more clinicians in all settings to use Alcohol Identification and Brief Advice intervention, which in itself acts as a successful treatment for increasing risk and higher risk drinkers.

Recommendation

Service redesign to a combined drug and alcohol treatment service should reflect the relative prevalence of need for drug and alcohol treatment. The need for alcohol services for dependent drinkers far outweighs the need for drug treatment services in Kent.

Alcohol Treatment commissioners

Aim to commission additional mainstream capacity for treatment of at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years, including expansion of specialist services to include inreach into acute wards and Accident and Emergency (Tier 3 services). Research shows that this is a cost – effective exercise (UKAAT, 2003, 2005), and it is one of the high impact actions identified by the Department of Health.

Aim to expand tier 2 services to meet the need for at least 10% of higher risk drinkers in west Kent, increasing to 20% over the following two years for those requiring specialist treatment identified by Identification and Brief Advice (IBA).

Dual diagnosis, co-morbidity, mental health disorders and social problems are common in people who misuse alcohol. Wraparound drug and alcohol services as envisaged in the new treatment specifications will need to link into mental health services at all levels, including signposting and referral to primary care psychological services.

Commissioned services need to be responsive in meeting the needs of changing ethnic minority profiles across Kent, including new communities. The 2011 Census report will inform this.

NHS Acute, Primary, Community Care and Mental Health commissioners

Good, responsive services on referral will encourage more clinicians in all settings to use Alcohol IBA, which in itself acts as a successful treatment for over 12% of increasing risk and higher risk drinkers.

Commission IBA in a variety of clinical settings for at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years using referral tools and pathways already agreed by commissioners and providers.

Use AUDIT-C within the NHS Health checks programme.

Commissioners of Cancer, Gastro and CVD acute services should ensure that alcohol IBA and referral mechanisms are explicit within their commissioned treatment pathways, using referral tools and pathways already agreed by commissioners and providers, and give consideration to the financial benefit of contributing to additional treatment service provision which will be needed as a result.

Industrialise routine delivery of IBA in Accident and Emergency and acute services generally for patients experiencing falls/accident/assault/head injury:

gastro-intestinal, cardiac, mental and behavioural problems: collapse or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers.

NHS Acute contracting team need to ensure that Hospital Trusts provide accurate data recording and data extraction, to monitor progress of initiatives, by building specifications on this into contracts and service level agreements. This will ensure that relevant data are available for performance management and to inform further JSNA refresh.

Industrialise routine delivery of IBA in Primary Care through inclusion in NHS Health Checks wherever and however commissioned and delivered, to mitigate risk of development of chronic conditions and identify patients requiring specialist treatment for alcohol harm reduction. Seek to Industrialise routine delivery of IBA in Primary Care generally for patients experiencing gastro-intestinal, cardiac, mental & behavioural problems or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers.

Industrialise routine delivery of IBA in Community Nursing, for the same groupings of patients and others who demonstrate health risk behaviour (e.g. in sexual health services). Use referral tools and pathways already agreed by commissioners and providers. Community commissioners to require accurate data recording and effective data extraction processes, by building specifications on data collection and data sharing into contracts / SLAs to monitor progress of initiatives.

Work for further development of generic young people's risk reduction services to include brief advice for alcohol identification and referral to specialist services (pathway development). This would be the responsibility of Child Health Commissioners, through and with KDAAT, alongside KCC Education.

Develop a joint working policy, procedure and care pathway for clients with mental health and alcohol misuse problems (significant co-morbidity with mental illness requires pathway development into alcohol / mental health dual diagnosis services). Use referral tools and pathways already agreed by commissioners and providers.

Develop links with the IAPT programme once that service is well-established.

Public Health Commissioners

Industrialise opportunistic IBA as part of Healthy Lifestyles services through local authority commissioning for prevention, and by Community Wardens, housing staff, anti-social behaviour officers.

Through co-commissioning and local partnerships, explore opportunistic delivery by non-specialist police and probation service staff including PCSOs;

and routine use of IBA with arrestees in custody suites (Alcohol Arrest Referral).

Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of drinking at increasing and higher risk levels and binge drinking. Give consideration to wider distribution of culturally appropriate resources for new communities.

2.3.5 Dental Health

Adults

- Twenty percent of adults in South East Coast have active tooth decay and 25% of older adults have severe gum disease, with 7% reporting pain.
- There is geographical inequality in uptake of primary care dental services and commissioned activity per population. Across Kent and Medway the dental activity commissioned ranged from 1.2 Units of Dental Activity per West Kent resident to 1.9 UDA per Medway resident. In the 24 months previous to 31 March 2011, the number of patients treated in West Kent represented 45% of the West Kent adult population compared to nearly 70% for Medway.
- Current population projections indicate high service need in future particularly for the elderly.
- National surveys provide data at the SHA level but there is a lack of local data.

Children

- Surveys carried out in 2007/08 and 2008/09 some 23.5% of 5-year-olds and 23.6% of 12-year-olds in Kent and Medway were estimated to have experience of tooth decay. Of those with experience of tooth decay, an average 2.8 decayed, missing and filled deciduous teeth (dmft) was reported for 5-year-olds and an average 2.0 decayed, missing and filled permanent teeth (DMFT) for 12-year-olds (Figure 2). Although lower in prevalence and severity when compared to the regional (South East Coast SHA) and national average, geographical variations in the experience of tooth decay within Kent and Medway are clearly evident..

Recommendation

Adults

A review of specialist dental services is required. For example, there are no sedation services in West Kent and domiciliary services need to expand their provision.

A targeted approach to health promotion initiatives is required particularly in the elderly.

Children

Further information required such as survey of dental health of under 5 year old, as well as a coordinated approach involving primary care dental services to focus on prevention in line with *Delivering Better Oral Health – a toolkit for prevention* by Department of Health

2.4 Children

2.4.1 Early Years

- What happens in the early years of a child's life is crucial for later life development. Research on brain development shows that its structure is formed by experience in the first few years of life (and more particularly the first few months). Early interaction between babies and their carers have implications for brain development. The quality of these relationships has profound implications for a child's emotional and cognitive development as well as for future mental health.
- The secure child is more likely to do well at school, form satisfying relationships, develop a capacity for compassion and empathy and have inherent resilience in the face of misfortune. Children who experience poor relationships in their early years with adults who care for them, have a greater likelihood of developing significant mental health problems, conduct disorder and educational difficulties.

Recommendation

Universal programmes (e.g. baby massage, the Solihull approach, the neonatal behavioural assessment scale [NBAS], the Family Partnership model) are primarily concerned with the promotion of infant mental health. Targeted programmes, e.g. Family Nurse Partnership and health visiting practise must be provided to families at risk of poor outcomes due to a range of social dysfunction or psychological pressures.

2.4.2 Breastfeeding

- Breast feeding is not being sustained into the early months of infancy for a large number of children. However there has been a welcome increase in rates of breast feeding in east Kent over the last three years, the position in west Kent being unchanged.
- Nine out of 10 women who stop before week six are reported as saying that they wished to have breast fed for longer. The fastest drop-off in breast feeding rates happens within the first four days of birth (12%). A third of women have stopped breast feeding by week six so that only 50% of babies get any breast milk at this stage. By six months only 26% of babies continue to be breast fed.

Recommendation

Implementation of the 'Baby Friendly' initiative to which all key stakeholders are signed up to, this includes, health visitors, children's centres and maternity units, will improve the uptake of breastfeeding as women will feel more supported.

- Support to mothers breast feeding should be commissioned according to the stated evidence base and the number of mothers breast feeding needs to be substantially increased in all parts of Kent.

2.4.3 Immunisation and Vaccination

- There are a number of vaccination programmes these include childhood immunisations, influenza, HPV and Hep B
- The percentage of children being immunised in accordance with the national vaccination and immunisation schedule by the age of one, is broadly lower than the national and SHA figure in East Kent. In the west of the county uptake is generally better.
- To improve the east Kent performance a National Support Team (NST) has reviewed local practice and made 29 detailed recommendations as part of a strategy to improve vaccination and immunisation, which inevitably focuses upon children and young people.
- By the second birthday, the overall percentage of children immunised in Kent is better than the England average and the SHA.
- The MMR rate in east Kent whilst improving is not at the 95% level recorded by the WHO as being necessary to prevent an outbreak requiring further public campaigns to bolster the uptake rates.
- HPV vaccination uptake has recorded varying levels (for each of the three scheduled doses) across Kent and Medway in comparison regionally and nationally.
- A project in conjunction with colleagues from the Somme is being developed to assess the differences in uptake of the HPV vaccine, to share best practice and to ensure that uptake of all three doses of the vaccine is maintained.

Recommendation

An action plan to increase the uptake of the MMR vaccination across Kent is required. CCGs should improve access to the MMR vaccination for their patients. To reduce variation within practices and ensure that all areas have a level of vaccination which offers herd immunity i.e where enough people are vaccinated within the population to minimise the risk of spread of infection. This will require targeted initiatives to ensure a pattern of optimised take-up of MMR vaccination across Kent.

Increase the uptake of HPV vaccination for all three doses, through the developing a targeted approach for those populations where uptake is lowest to reduce variation across Kent.

Develop a local enhanced service [LES] to improve uptake of influenza vaccination including workforce within primary and community care and all professionals who come in direct contact with patients and clients.

Increase uptake of influenza vaccination through the use of healthy living pharmacies.

Ensure that Hepatitis B vaccination is offered to all at risk mothers

2.4.4 Children's Centres

- The results from the later evaluations of the National Sure Start Programme (NESS) have shown that this programme produces positive results. However the programme needs to be sustained for a number of years more to demonstrate robust results which are statistically reliable.
- Children's centres need to bring the benefits of joined-up play groups, healthcare and parenting support to the local population that they serve. They should be a hub for the local communities that they serve.
- Universal services (health, social care and third sector provided) need to be maintained in children's centres. The services provided by children's centres should be evidence based, practitioners should be highly skilled and there should be a continued commitment to support families' economic wellbeing and financial independence.
- Health visitors should work from children's centres, thereby focusing on early intervention, prevention and health promotion in a setting where they can have the greatest impact. In this regard health visitor practise should reflect a detailed knowledge of the communities in which they work and with other professionals and agencies both statutory and voluntary. Health visitors should use the capacity of children's centres to deliver intensive programmes for the most vulnerable children and families.
- There is a national programme to increase substantially the number of practising health visitors and a Kent and Medway working party will co-ordinate the development of this programme to ensure that full quotas of newly recruited and trained health visitors meet required targets by 2015.

Recommendation

A balanced range of services from health, social care and the third sector should be provided from children's centres. The current focus from social care excessively focuses on families in need. Health services are universal and offered to children and families as of right. To enable the health service offer within children's centres attractive, the role of children's centres should be broadly based and all services (regardless of commissioner) should not just be targeted on the needs of vulnerable families.

2.4.5 Parenting

- The relationship between infants and parents or primary caregivers is critical to the child's emotional, psychological and cognitive development. Developmental and behavioural problems – often continuing into later life – most commonly arise from disturbances in that relationship.
- Historical impact of Sure Start programmes have yielded mixed results in terms of developmental trajectories of young children. Recent results of Sure Start Local Programmes showed children displaying more positive social behaviour and greater independence and their parents less negative parenting and a better home environment.

- However there are concerns have arisen relating to the extent of local boards running these services, their provision of child care services and most importantly, the long term funding.

Recommendation

Agencies in Kent should maintain their commitment of differential funding to first wave Sure Start Children's Centres on the basis that these have been set up as targeted resources in areas of the county identified as being in greatest need. This is a proper application of the principles of equity.

2.4.6 Childhood obesity

- The National Child Measurement Programme indicates fluctuating levels of obesity in Year R but a steady increase in prevalence in Year 6 from 2007 – 2010, in Kent.
- In 2009/10 the percentage of children in year 6 who were classed as overweight or obese in Kent was 32.9%, ranging from 29.5% in Sevenoaks to 37.9% in Dartford.

Recommendation

Obesity services and healthy eating interventions children should be commissioned based on national and international evidence such as treatment programmes to assist changes in child and family behaviour, social marketing techniques promoting healthy lifestyles, systematic collection of local data, etc.

Substantial investment in programmes to address obesity in children and young people in Kent should be made covering:

- A focus in early years and school settings that fosters a healthy environment, including the provision of active help for children at risk of becoming overweight;
- Support treatment programmes to assist changes in child and family behaviour towards maintaining a healthy weight;
- The appraisal of the potential of social marketing techniques to communicate simple and positive messages about healthy lifestyles;
- The provision of appropriate workforce training and the development of a targeted evidence of what works specifically as regards children and young people;
- The systematic collection of local data;
- An action-learning approach to treatment interventions.

2.4.7 Avoidable injury

- Road accidents involving children are more scattered than those involving adults with an obvious relationship to the roads near home.

- While the numbers of road casualties have decreased across all District Authorities over the last 15 years, Thanet and Maidstone still appear to have relatively higher number of casualties than the rest.

Recommendation

Multi-agency initiatives in Kent to reduce accidents whether on the road or at home and in leisure facilities should continue. Transport planners, road safety experts as well as other local authority officials need to have greater ownership of this agenda.

2.4.8 Children in care

- Kent continues to have a higher proportion of looked after children who are aged 16 and over than the national figure but a smaller proportion of looked after children aged under 10 years old.
- There is an increased proportion of white looked after children from 2009 to 2010 with the proportion of Asian or Asian British looked after children falling, but this does not match the national picture which has stayed static since 2009.

Recommendation

The 2010 OFSTED review highlighted the inadequate child safeguards and protection arrangements as well as lack of robust quality assurance and performance management systems, and has suggested a number of recommendations including a review of the current caseload, workforce capacity, and improving the quality and timeliness of assessment process.

All agencies need to be mindful of the continuing need to support young carers and young carer's projects. KCC's strategy 'Invisible People: A multi-agency strategy for young carers in Kent' should continue to be implemented.

All agencies but in particular KDAAT, need to focus on the specific needs of children whose health and development are frequently compromised through alcohol and substance misuse by parents.

2.4.9 Domestic Abuse

- In Kent there are very few services specifically for children affected by Domestic abuse. Services which raise awareness, change attitudes, allow an environment where people are comfortable making disclosures, and provide early interventions which prevent problems from escalating can all be described as Preventative. The majority of prevention services are universal and provided by statutory services, such as health and education.
- Need to protect access to domestic front line services

Recommendation

The framework of domestic abuse services across the County has been grown and largely sustained through the third sector. In consequence accessibility to services varies across the County. The Kent Ambition Board Two Tackling Disadvantage should promote a County-wide framework for these services and promote sustained funding solutions to enable the voluntary sector to continue to provide appropriate interventions for people who suffer domestic abuse. In this regard it is important to recognise that the true level of need is grossly under-estimated and will take some years to establish.

Increase training and raise awareness among professionals in spotting signs of domestic violence

Ensure that there are sufficient referral centres for victims of domestic violence to receive help.

Undertake robust evaluation of perpetrator programmes run in Kent and Medway to establish effectiveness in reducing violent assaults over a number of years

Child and Adolescent Mental Health (CAMHS)

- Kent CAMHS services in 2009/10 were seeing fewer than expected proportion of children according to need in Tier 2
- There is a considerable percentage of self harm and psychosis seen in Tier2 and Tier 3 services.
- In Kent slightly fewer males and slightly more females access services than would be expected nationally
- There is an under representation of conduct disorder and hyperkinetic disorders and fewer younger boys are being seen than expected nationally
- Although smaller numbers of Black and Minority Ethnic (BME) groups are expected in Kent CAMHS services than nationally, Kent CAMHS have an underrepresentation of African and Caribbean children and an over representation of Asian and mixed race children than is expected.
- Kent CAMHS are seeing more children with learning disability than expected nationally but children looked after and young offenders are under represented both according to local need and to national comparison.
- CAMHS services are being accessed by more children and young people aged 10-14 than at 15-18
- There is a gap in transition services from CAMHS to Adult services.
- There is under representation from BME groups from a number of providers notably NHS West Kent where there is a large Asian population. Kent and Medway Partnership Trust (KMPT) is seeing expected numbers of mixed race children and Asian children. KCC reports large numbers of White Irish, White Other and mixed race young people.

Recommendation

- Focusing work on vulnerable groups : particularly CAMHS Tier 2 and Tier 3 support for young offenders and Children looked after
- Children with mothers with mental health problems and children with alcohol dependant children is a high impact area that needs addressing. This would be achieved through working more closely with adult services to identify, risk assess and intervene in family support and provide good Tier 2 type support for those children at risk.
- Improve equity : e.g BME engagement
- Emotional well being services and support need to be targeted to areas of key deprivation (Thanet / Shepway/ Swale/ Gravesham)
- Better Data quality and on going needs assessment using real time data to test for equity and outcomes

2.4.10 Teenage Pregnancy

- National guidance estimates that for every £1 invested in contraception saves the NHS £11 plus additional welfare costs, which is a powerful economic argument for maintaining contraceptive services.
- In Kent the teenage pregnancy rate is 34.7 per 1000 females 15-17 years (2009) which compares favorably to an England rate of 38.
- Thanet has the highest level of teenage conceptions within Kent (53.6 per 1,000 females aged 13-17).
- Rates in Kent have reduced by 18% from a baseline of 1998 similar to the national trend.
- However there is still significant variation in progress to rate reduction such as in Maidstone where there has been a 10% rise with a strong association to deprivation.
- There is a significant lack of information concerning particular at risk groups such as BME, young fathers, looked after children, young offenders where more detailed needs assessments should be carried out.
- Dartford, Maidstone and Sevenoaks are the districts with the highest rates of termination of pregnancy in this age group. However, there is only service provider operating from Maidstone for the whole county and so there is a need to offer termination services elsewhere.
- There is also disparity in the number of sites offering LARC (long acting reversible contraception) as mentioned in the recommendations for Sexual Health improvement.
- Apart from the above, the teenage Pregnancy Action plan also links in with other partners, services and strategies such as Children Centres, Relationship and Sex Education in schools, etc.
- To reduce the number of girls who have repeat abortions three outreach workers have been employed to identify girls at risk and to provide support and information to improve their awareness of good sexual health.

Recommendation

Unlike some other counties, Kent has retained a Teenage Pregnancy Co-ordinator and a County-wide framework of district-based Teenage Pregnancy Groups. This framework must continue to be sustained as must the

programme of planned reductions in rates. Teenage pregnancy whilst complex, is significantly a product of lack of aspiration. The risks to the programme of planned reduction through the lack of prospects for many young people at present places the success of this programme at particular risk.

Whilst prevention of pregnancy is preferable, termination services should be re-tendered for to allow for ease of access across the County. The current base of Maidstone disadvantages young people faced with this dilemma living in east Kent. A model that has two bases that serve respectively east and west Kent needs would improve access.

2.5 Adults

2.5.1 Long term conditions

- Chronic obstructive pulmonary disease (COPD) – Quality Outcomes Framework (QOF) recorded prevalence is approximately 2% with another 1% undiagnosed totalling to over 35,000 patients in Kent. Generally there are more undiagnosed cases in the west of Kent, taking into account the undiagnosed patients east Kent still has a higher prevalence, linked to deprivation, but mortality rates are slightly higher in East Kent, at around 27% and more than the England average.
- Cardiovascular Disease (CVD) – Prevalence is expected to increase by at least 0.6% over the next ten years to 2020, with East Kent having a consistent prevalence of 1% higher than West Kent. Swale, Thanet, Shepway and Dover appear to have relatively higher mortality rates compared to the other districts in Kent. This will have profound effects on access and demand for cardiac services for surgical treatment, revascularisation and rehabilitation.
- Diabetes – the age adjusted prevalence of Diabetes has increased slightly from 5.4% to 5.7% in Kent. Eighty six percent of the diabetics are Type 2 while the rest are either Type 1 or other rare forms.
- Cancer – While there has been an increase in incidence and the survival rates of some cancers such as breast, skin and prostate, lung cancer continues to have the lowest survival rate this is due to a high proportion of people having the disease diagnosed at a late stage, when the cancer is more advanced., emphasising the important of increasing public awareness of signs and symptoms encouraging early presentation in primary care, as mentioned in the national Cancer reform strategy. Innovation in delivery of appropriate care is also of emerging importance with examples such provision of laparoscopic surgery, Enhanced Recovery after Surgery and systematic approach to chemotherapy pricing.

Recommendation

Diabetes

Greater emphasis on obesity prevention is essential for prevention of Type 2 diabetes. Therefore greater service integration is required with the Kent Healthy Weight Care Pathway for Adults and Children right through to

specialist diabetes services. This should be a priority for CCGs as early prevention will enable savings on treatment which can be invested elsewhere.

Cardiovascular disease

The continued implementation of health checks ensure risk factors for cardiovascular disease are identified at an earlier stage to delay onset of long term conditions.

Review of cardiac rehabilitation services

Primary event ranging from acute heart failure to primary PCI

Assess the gap in service provision for cardiac rehabilitation services

Review of defibrillation

2.5.2 Screening

- Screening aims to reduce illness and deaths from certain preventable diseases. NHS national screening programmes exist for:
 - Antenatal and Newborn Screening (infectious diseases, sickle cell and Thalassaemia. fetal anomaly (includes Down's), Newborn (bloodspot, hearing and Infant physical examination)
 - Diabetic Retinopathy
 - Abdominal Aortic Aneurysm
 - Cancer (cervical, breast and bowel)
- The level of uptake in Kent and Medway for all screening programmes is good.
- There has been more than a 50% uptake in Bowel Cancer screening in 2010 with plans to extend the screening age up to 75 years.
- The diabetic retinopathy screening programme is meeting key national standards however further work is needed to improve the accuracy of the database used for invitations and also to improve attendance for screening
- The abdominal aortic aneurysm screening programme started in 2011 and is running successfully.
- In March 2012, the cervical screening programme will incorporate testing of cervical screening implies samples for the virus that caused almost all cervical cancer, Human Papilloma Virus (HPV). This will improve further the accuracy and efficiency of the screening programme.

Recommendation

Reorganisation and safety

- It has been shown repeatedly that service reorganisation can easily lead to unsafe and ungoverned screening programmes. It is essential that those responsible for leading, commissioning and quality assuring screening programmes at PCT, SHA and Quality Assurance level are able to continue to focus of safe deliver of screening programmes

Programme development, higher national standards increased expectations.

- All programmes are developing and revised standards appear for programmes on a frequent basis. There is also an expectation to provide more thorough governance and assurance following recent

serious incidents (elsewhere). Coordination and leadership of these require appropriate resourcing.

2.5.3 Dementia

- The current prevalence (based on national estimates) is approximately 1.36% and 1.18% for Eastern & Coastal Kent and West Kent respectively equating to a combined prevalence of 1.28%, far higher than the General Practice recorded prevalence of 0.49%. This equates to approximately 17,400 people in 2006 rising to 30,100 in 2026.
- Shepway, Sevenoaks, Tunbridge Wells, Tonbridge and Swale are district authorities with greater growth of dementia patients.
- One third of patients live in care homes as well as high risk groups such as learning disabilities and ethnic minorities.
- The QIPP work plan has outlined a number of initiatives which allow better partnership working and service integration such as crisis resolution, domiciliary care, advocacy, awareness raising, specialist memory assessment, integrated case management, etc.

Recommendation

Move to a social model of care for people with Dementia and map the cost of the current system and map the change in costs as care moves to the community.

Significant shift in hospital to community care and costs can be made.

Agree a dementia pathway with all clinicians on the pathway and monitor its implementation

Earlier diagnosis of Dementia by GPs to a prevalence that is expected in Kent so services can be offered earlier and not in a crisis situation.

2.5.4 Falls and Fractures

- There has been a 53% increase in falls related hospital admissions in West Kent compared to 30% in East Kent over the last 5 years. Almost 65% of these admissions resulted in no fracture and or injury. The cause of the fall is more often related to medical and social reasons such as UTIs, dementia, pneumonia, and condition of housing.
- The 2010 national falls and bone health audit showed considerable variation in access and availability of minimum standards of care across the community and acute Trusts in Kent, particularly secondary falls prevention and bone health assessment including home hazard assessment. However it may be noted that ECKHT performs relatively better than MTW and DVH on some of the indicators including the above mentioned.
- Discussions have already under way in West Kent to implement, step by step, a five point integrated action plan consisting of hospital and primary care based fracture liaison services, integrated elderly care rapid access clinics including specialist assessment for falls and osteoporosis,

community based therapeutic exercises and falls call out response services.

Recommendation

The results of the National Falls and Bone Health Audit 2010 give the local picture on how well we are achieving the required standards

In the light of recent admission and ambulance activity trends explained earlier, it has been suggested to reconfigure falls and bone health services in West Kent by:

Commissioning acute care fracture liaison service* based at Acute Care trusts (as recommended in Objective 2 of the DH paper (2009) above).

Commissioning primary care-based fracture liaison service* - mainly concerns pro-active case finding through GP databases for patients at high risk of osteoporosis and falls (as recommended in Objective 2 of the DH paper (2009) above) as well as providing adequate capacity for onward referral for DXA scanning.

Reconfiguring community-based falls clinics to be jointly carried out by ortho geriatricians and community health teams, possibly as rapid access clinics (in line with having a Falls Service as per Objective 3 of the DH paper (2009)). In the north of west Kent, discussions have been initiated by the GPCC with the DVH and local intermediate care and rapid response teams for an integrated rapid access clinic which will be geriatrician led, carrying out holistic assessment of patients, focusing on falls assessment. ECK have also outlined this as one of their commissioning intentions as well.

Commissioning local authority-based postural stability community therapeutic exercise programmes across west Kent clinics (in line with Objective 3 of the DH paper (2009)). A six month pilot funded by the SHA to refocus and build on the existing programmes to encourage formal referrals from GPs and other health professionals rather self referrals. The pilot is to be carried out both in Dartford Gravesham and Swanley and west Kent and Weald (Salveo)

Commissioning community/local authority-based falls call-out service(s), possibly in the form of community call-out vehicle/community mobile warden/community alarm/community volunteer service as diversion from South East Coast Ambulance Service (SECAMB) (taking non-conveyed by ambulance patients to other services as suggested in Objective 4 of the DH paper (2009)). A number of pilots are currently operating elsewhere in the country. Most notably the integrated service between East of England Ambulance and Hertfordshire Council Adult Social Services.

2.5.5 Mental Health

- The data that is currently available, together with national models of need suggest that people in Kent have a little less degree of mental health 'need' compared to the England average. However Kent is a large County with significant local variation and the mental health needs vary according to socio economic status, variations in local well-being resources and access to timely services making equity audit essential.
- People with poor mental health also experience poor physical health and reduced life expectancy. There is a need to improve physical healthcare provision for those individuals with chronic mental illness, offering health checks to people with mental health problems is important.
- Equity Audits in the provision and access to community mental health teams and psychological therapies is a priority in Kent.
- Promoting positive mental wellbeing will require a partnership approach that cuts across a number of agendas, to effectively tackle the factors that can impact on an individual's mental wellbeing e.g improving community cohesion and 'social capital'.
- There are currently gaps in service provision to need in dual diagnosis (alcohol and mental health), transition services between child and adult mental health services, services tackling maternal depression and maternal mental illness, older people's mental health (excluding dementia) and eating disorders, personality disorders, offenders in the community and veterans. Many of these issues are being tackled in the current commissioning intentions for 2011 and 2012.
- The mental health needs of Black and minority ethnic communities and high-risk groups, such as offenders and asylum seekers/refugees need to be better understood to ensure appropriate service provision in Kent.
- Further needs analysis, assessment and targeting of older people (excluding dementia) are needed.
- Of Kent's population of adults with severe and enduring mental health problems, only 8% are in employment, improving the employment prospects of people with mental health problems is important.

What is Currently Happening in Kent to Improve Mental Well Being and Mental Health of Adults in Kent.

- There is a comprehensive strategy and commitment to tackle Mental Well Being in partnership between the Council, Voluntary Sector and NHS. This is called "Live it Well" <http://www.liveitwell.org.uk/>
- There is an accessible website of information which is being updated regularly to provide help and information to the public. There is a plan to provide information in other accessible formats too in 2012.
- There is an East Kent and West Kent Mental Well Being Strategy. These are plans and commitments of many agencies working together to raise the awareness of mental well being. In 2012 these will be united and updated.
- The NHS and the Council will work together with the voluntary sector to publicise campaigns to reduce stigma and improve awareness of well being.

- The Kent Public Health team are working with NHS and Council commissioners to provide better analysis and information to improve equity of service use e.g liaison psychiatry, community mental health and primary care mental health services.
- The Kent Public health team with its partners are implanting a series of well being initiatives such as Change 4 Life, Health Trainers, Healthy Living Pharmacies, Active Mobs and Well Being Impact Assessment – all of which have an impact on well being.
- There is a systematic approach led by Kent council and Kent Police - to improving awareness and service access for people suffering domestic violence.
- There is a comprehensive commissioning plan set out in the ‘Live it Well’ commitments and is described below.
- There are community development workers working alongside a voluntary organisation in Kent and Medway to improve equity and access for people in vulnerable and minority groups.
- There is a focus on the mental health of ex military service people (Veterans) and an initiative to improve mental health services for them is underway.

Recommendation

- Refresh the data collected in the 2009 Mental Health Needs Assessment and evaluate performance using service outcome measures.
- Ensure services are commissioned that are accessible to all, including those at highest risk, have an emphasis on promoting recovery, and consider an individual’s physical health needs as well as their mental health needs.
- Promote equity at the heart of the “Live it Well” strategy.
- Commission initiatives that address the employment and accommodation needs of adults with mental health problems and evaluate their success.
- Develop a strategic approach to improve the mental well-being of Kent County that also addresses the broader determinants of mental health and can measure the impact of changes to well being.
- Scrutinise and assess the needs and care of the elderly people in mental health services.
- Implement actions from the **Strategy for the reduction and prevention of suicide in Kent 2010-2015**
- Improve the mental health outcomes of veterans and ex-offenders in the community.

Older People’s Mental Health

- Work with all Commissioners to redesign the OPMHN/Dementia Care Pathways, ensuring services are more community/primary care focussed, integrated with community health services and collaborating to support the private and voluntary sectors
- Review the role of day treatment services in east Kent
- Decrease acute in-patient mental health capacity by 15 beds in east Kent

- Review all KMPT OPMHN inpatient units, including continuing healthcare, to assure best value for money; and undertake benchmarking market development exercise with independent sector
- Explore and develop models of integration in acute (non mental health) care or primary care; for case management, and joint working between intermediate care, acute and community services – resulting in fewer general hospital admissions for people with dementia.

Learning Disabled Mental Health

- Analyse data to inform a needs assessment that in turn allows design of an options appraisal for the future commissioning of in-patient services for people with learning disability and mental health needs
- Analysis of demand, activity and costs of the service to consider whether contracted bed numbers should be reduced to allow investment in learning disability community forensic services
- Commission additional nursing posts in support of the community mental health of learning disability service.

2.5.6 Learning Disabilities

- People with learning disabilities (LD) have a wide range of social and health care needs depending on the severity of their condition.
- The latest estimated prevalence for LD in Kent by reference to QOF data is approximately 0.3%, with higher rates recorded in Dover, Thanet and Shepway.
- However, this appears to underestimate the prevalence estimates from the national epidemiological literature considerably, by up to 3% of the population. This implies a important training need particularly around specialist assessment, diagnosis and chronic disease management to improve recording of prevalence.
- As of January 2009 an estimated 29,000 primary and secondary school children in Kent have been identified with a disability requiring Special Educational Needs. The Aiming High for Disabled Children programme aims to improve services by local focus on improved access, parent / carer support, social networks and information.
- The majority of learning disability cases are due to genetic factors.
- Over the last few years, there has been a change in need and people with learning disabilities are choosing to live more independently, seeing a shift away from residential care, to more community based, flexible services to meet individual person centred plans.

Recommendation

Continue to support the Aiming High for Disabled Children programme which aims to improve services by local focus on improved access, parent / carer support, social networks and information.

2.5.7 Sexually Transmitted Infections

- The England average rate is approximately 775 diagnoses per 100,000

population whereas NHS Eastern and Coastal Kent and NHS West Kent are much lower at 573 and 519 per 100,000 respectively. Genital Warts, Chlamydia and non specific genital infections make up the majority proportion of STIs diagnosed.

- For Chlamydia, the female age group 16-19 years appears to be at the highest risk across Kent among the other age groups, in line with national trends.
- A community sexual health model for Kent will be implemented from April 2013.
- Late diagnosis of HIV appears to be a problem particularly for West Kent with 55%, compared to approximately 20% in East Kent.
- A research project looking into reasons for late diagnosis of HIV is being developed in conjunction with the Health and Europe Centre.
- Projections estimate a 23% and 28% increase in first attendances for GUM clinics for East and West Kent respectively.

Recommendation

More work is still required to map, integrate and improve uptake of sexual health services like Chlamydia testing and long acting reversible contraception.

To ensure earlier diagnosis of HIV work needs to be undertaken to increase the up-take of point of contact testing for all patients in contact with services. An HIV test should be offered routinely through General Practices and Community Services.

Ensure that as part of the Healthy living pharmacies programme, there is a requirement to promote good sexual health and to deliver Chlamydia screening, Emergency Hormone Contraception (EHC) and the prescribing or oral contraception.

Continued investment and development of a Kent and Medway Sexual Assault referral centre (SARC)

2.5.8 Offender Health

- There is a high rate of non-attendance at appointments offered within healthcare at some prisons in Kent such as refusal of psychological interventions associated with the Integrated Drug Treatment System (IDTS) and low uptake of Hepatitis B vaccination, coupled with high rates of smoking and hazardous drinking.

Recommendation

Development of clear pathways and referral processes that enable offenders currently in as well as leaving custody to access community drug and alcohol services and other health care services including health checks.

There is a need for a Medicines Management Performance Framework to be in place to harmonise prescribing and medicine management financial practice across the Sheppey prison estate

There is a need to ensure that timely and appropriate screening has taken place including screening for Bowel Cancer and AAA.

Bedwatch and escort events should be subject to a special review to ensure that as many clinical services as possible are offered in the Prison.

There should be a specific review of In Patient facilities in HMPs Elmley and Swaleside

2.5.9 Excess Winter Deaths

- There is considerable variation between the different districts in Kent; with Canterbury has the highest excess winter death ratio (ie. Winter vs summer), followed by Maidstone and Dover having the lowest ratio. Most of the local authority districts have ratios that are relatively close to the Kent average.
- There is a service gap in terms of the link between primary care and those able to offer support to the people most vulnerable from poor health outcomes due to cold temperatures.
- A number of pilots have been suggested or implemented such as GP practice winter warmth referral, which, if successful, should be rolled out to other areas.

Recommendation

- Consider the results of the pilot evaluation when complete to assess if the scheme is feasible to roll out to other areas.
- Commissioners should support local initiatives within local districts such as community wardens giving out portable thermometers to people over 65 in specific geographical areas
- Identify way in how agencies can work together to identify those at greatest risk of morbidity and mortality due to cold weather.
- Work with voluntary and community sector to explore how they can deliver interventions to those at risk.

2.6 Other important QIPP work streams

2.6.1 Urgent care

National evidence shows almost a 12% rise in unscheduled care activity from 2004 to 2009 attributed to a number of factors such as population age distribution changes (towards more elderly), central policy initiatives like 4 hour A&E waiting targets and advances in clinical practice leading lower threshold for decision to admit. In Kent, due to a variation in quality and practice of submission of non elective data across different local provider trust organisations, non elective activity cannot be accurately described. However,

there is clear evidence indicating conversion rates from attendance to admissions are increasing steadily with age. Non-elective admission rates for ACS conditions such as COPD are also consistently higher in East Kent than West Kent.

2.6.2 End of Life Care

Both NHS West Kent and Eastern and Coastal Kent have signed up to the national Dying Matters Coalition, which seeks to raise awareness of death, dying and bereavement, and to encourage early discussion and planning. Development work must be underpinned by analysis and evidence of local need, both now and in the future. Currently there are no precise indicators or measures that can accurately measure the end of life care need and activity. Some proxy measures that have been used such as proportion of patients dying at home which is approximately around 35 to 40%, implying the need for further research and development around this.

2.6.3 Maternity and Babies

The population of women of a childbearing age is projected to increase in the Dartford and Gravesham Local Authority areas (~9% over ten years), and to a lesser extent in the Ashford, Canterbury and Sevenoaks areas (~1-2%), although overall the population of women of a childbearing age in Kent is projected to decrease slightly.

East Kent has consistently higher infant mortality rate compared to West Kent but not significantly different from the England average. Focus on new tests such as fetal fibronectin to predict preterm labour and development of robust indicators to monitor variation in caesarean section activity across provider organisation has been recommended.

2.6.4 Planned Care

First appointment follow up ratios for outpatient activity are consistently higher in cancer specialties like oncology and haematology. Total elective care activity is consistently higher for East Kent compared to West Kent till 2009/10. For example, skin lesion procedures have increased by 82% in East Kent over the last five years compared to just 6% in West Kent. It is unclear to what extent this difference in activity reflects unmet need, variation in clinical practice or other factors. A number of demand management initiatives have already been suggested such as Enhanced Quality Programme for hip and knee replacements, review of high risk low gain procedures, cataract pathway redesign, teledermatology triage for skin conditions, etc.

2.7 Social factors

2.7.1 Housing and homelessness

- The estimated shortfall in affordable housing far exceeds what will be delivered through new supply. Collectively, the housing need assessments that have been undertaken across the County would suggest that there is an annual need for almost 12,000 additional affordable homes.

- Shortfall in housing varied in Kent partly due to percentage and absolute growth in population in each of different areas.

2.7.2 Carers

- Current estimations show that one in ten people in the UK is a carer; the percentage in Kent is even higher, on average 12.58 per cent, rising to 14 per cent in Thanet. Based on the 2008 Mid Year Population Estimates, which is the latest government dataset, there is now an estimated 139,500 carers in Kent.
- A number of wider determinants and factors influence the background of the carers as well as intensity of care, in a community such as area deprivation, age, whether from ethnic minorities, as well as the physical or mental health problems of the persons receiving care, particularly dementia.
- The 2001 census indicates higher proportion of older age carers, starting from children aged 10 years and peaking between 50 to 60 years of age for both males and females.
- A recent survey describes a correlation between age of carers, hours spent on caring and decline in carer health.
- Due to the lack of more recent data, there is a need to update the full extent of carers in Kent particularly unknown carers who have yet to self declare their role, possibly through the use of MOSAIC analysis.

2.7.3 Community Pharmacies

- All PCTs in England are required to publish a Pharmaceutical Needs Assessment. These will be used to determine future applications to provide access to new pharmaceutical and dispensing services will be approved.
- In West Kent dispensing services are provided by 113 pharmacies and 32 dispensing practices of which six were '100 hours' pharmacies situated relatively evenly across the six localities. Consultation showed that this level of access to extended hours is the minimum needed; any reduction in the opening hours of those pharmacies would create a gap in service provision.
- In East Kent, consultation indicated access to pharmaceutical services beyond the normal pharmacy contractual hours of 40 hours per week. Thus '100 hour' pharmacies are not allowed and those pharmacies with 100 hour contracts are to reduced to a 40 hour contract. Consultation shows the need for 100 hour contract provision on the Isle of Sheppey and in the town of Dover. East Kent consultation showed that there was a need for better understanding of the access to enhanced services such as emergency contraception provided by pharmacies and other contractors.
- Training of pharmacists and their staff in preventive health is required in order to work towards the development of pharmacies delivering 'Healthy Living Centre' functions in conjunction with other providers.

Veterans

- .Local modelling suggests there are approximately **130,000 veterans** in Kent and Medway, with the highest density in Thanet, Dover, Shepway, Swale and Medway.
- The armed forces recruit heavily from deprived communities, veterans are known to have lower than average household incomes, and in Kent and Medway the areas with the highest prevalence of veterans are also some of the most deprived
- The focus for Kent and Medway is recent veterans, particularly those deployed to Iraq and Afghanistan. This is the group with the most *distinctive needs*, and where interventions and alterations to services are most likely to have a beneficial impact on long-term health outcomes
- A typical UK recruit is a relatively poor, white teenager with limited education and work prospects, recruited from a difficult home environment into the Army infantry. An estimated 86% of UK veterans are male, 94% are white, and only 9% of recruits have a GCSE grade A* to C in English (compared with a 61% national average). For these young men, military service can be a very positive intervention.
- Although the rate common mental illness (depression and anxiety) are not higher than that observed in the population at large, military personnel and veterans were found to be misusing alcohol, more than twice the rate observed in the general population, 13% for military and 6% in the general population.
-

Recommendation

Recommendations are made in 4 key areas; the transition from The Defence Medical Services (DMS) to the NHS; physical health services for veterans; mental health services for veterans; and raising awareness of veterans' issues:

- **Transition from DMS to the NHS**
 - Facilitate GP registration prior to discharge
 - Improve awareness of DMS record transfer
- **Physical Health Services for Veterans**
 - Review Kent and Medway's prosthetic limb service to allow implementation of Murrison Review
 - Raise awareness of the principle of prioritisation
 - Support extension of the SSAFA referral project from custodies to A&Es
- **Mental Health Services for Veterans**
 - Local implementation of the Murrison Report on veteran mental health based on the findings of this health needs assessment

- Targeted support for veterans known to be at high risk of mental health problems
 - Regional qualitative research to allow the veteran voice to influence mental health services
 - Fully map and integrate mental health provision for veterans
 - Continued local representation on the South East Coast Armed Forces Forum Mental Health Working Group
 - Exploratory work with KDAAT/Medway Alcohol Services about service accessibility for veterans
- **Raising Awareness of Veterans Issues**
- Maintain and expand the Kent Military Health Working Group
 - Raise the profile of the Welfare Pathway
 - Armed forces/veteran representation or close link to/on Health and Wellbeing Boards

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3 Ashford Clinical Commissioning Group (ACCG)

3.1 Demographics

Ashford locality commissioning group is made up of 16 practices. 15 of the practices are located within the district boundary of Ashford and 1 is located within the district boundary of Shepway.

3.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 122,599¹ people are registered to practices within ALG this is 8% of the total registered practice population for Kent.
- The population age and sex structure is similar to that for the total Kent and Medway registered population.
- There are slightly more people registered between the ages 40 and 49 and slightly fewer aged between 20 and 39.
- Using data for Ashford District, the population is projected to increase by 6% over the next 5 years² and 13% over the next 10 years. The greatest population growth is in the 65+ (18%) and 85+ (17%) age groups.
- Kent as a county has a predominately white population estimated at 92% in 2009. The proportion of the population from Ashford from a BME community is estimated to be 6.7%, .
- Life expectancy for ALG is 82 years compared to 80.9 for Kent and Medway. The difference in life expectancy for wards is 13.1 years the lowest life expectancy is within St Michaels ward.

As the population ages more people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes. Dementia is predicted to be a significant issue.

3.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates most deprived.

- Ashford is ranked 198 out of 326 local authorities, and 8 of the 12 Kent districts.
- 5.7% of Ashford lower level super out put areas are in the 20% most deprived for England.
- The highest levels of deprivation are found within Stanhope, Aylesford Green and Victoria, in an around Ashford town centre.

¹ PCIS registered practices populations September 2011

² ONS 2008-Based population projections 2011-2016, 2011-2021

3.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment within Ashford district is 2.6% [September 2011] lower than Kent (3.2%) and well below the level for the UK (3.9%).
- Unemployment in Ashford has increased by 10% since the September period 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed 30.5%. The rate for Kent 31.5%.
- 53.1% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 3.96% of households within Ashford are classified as statutory homeless; this is significantly higher than England (1.86%)

3.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Ashford (27%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males. There was a slight reduction in admissions to hospital for females between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Ashford (52.3%) compared to England (55.1%)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse than England (smoking 14% Breastfeeding 73.6%)

3.6 Health Issues

Prevalence

- The 2010/11 disease registers show that the population of ALG have a higher prevalence for hypertension, depression, obesity and Atrial Fibrillation, than England. Assessing variation at a practice level will enable the CCG to target resources.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care.

- ALG has higher emergency admissions rates for Diabetes and Stroke, than Kent and Medway
- COPD emergency admission rates are lower than Kent and Medway, however the trend shows that admissions are increasing.
- Emergency admission rates for Dementia are the lowest of all the CCGs. The trend shows an increase in Dementia emergency admissions but at a slower rate than Kent and Medway.

Mortality

- 77% of all deaths are from three main diseases: Circulatory disease (34.1% of all deaths), Cancer (29.4% of all deaths) and respiratory disease (13.5% of all deaths).
 - Mortality rate from Circulatory disease (Coronary Heart disease and Stroke) have been steadily declining since 1995, and the rate of premature mortality is lower than that of England. The same can be said for Cancer.

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4 C4 Canterbury and Whitstable CCG

4.1 Demographics

Canterbury and Coastal CCG consists of 23 practices, the majority of which (16) are located within the district boundary of Canterbury, four practices are located in Faversham within Swale District and the remaining three are located within Dover district. Dr Kinnersley has a branch practice located in Chilham which is in the district boundary of Ashford.

4.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 211,651 people are registered with practices within C4 this is 14% of the total registered practice population for Kent.
- The population age and sex structure differs from that for Kent and Medway. Canterbury is a university town and has a larger number of people aged between 15 and 29.
- Using data for Canterbury District, the population is projected to increase by 4% over the next 5 years³ and 8% over the next 10 years. The greatest population growth is in the 65+ (14%) and 85+ (11%) age groups.

The population group aged 15 to 29 is less likely to require social care services. Health promotion and lifestyle issues are key for this age group as they are likely to smoke, go out drinking and experiment with drugs. Sexual health services will also be a priority for this group.

4.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates most deprived.

- Canterbury is ranked 166 out of 326 local authorities, and is ranked 6 of the 12 Kent districts.
- 8.9% of Canterbury's lower layer super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Gorrell, Heron and Wincheap.

4.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people

³ ONS 2008-Based population projections 2011-2016, 2011-2021

suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Canterbury district is 2.3%, lower than Kent (3.2%) and considerably lower than the level for the UK (3.9%)
- Unemployment in Canterbury has increased by 12.3% since the same period 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed 33.4%. The rate for Kent 31.5%.
- 53.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 0.77% of households within Canterbury are classified as statutory homeless; this is significantly lower than England (1.86%)

4.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of smoking, obesity, physical activity and healthy eating are all similar to the rates for England.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males.

Children

- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse than England (smoking 14% Breastfeeding 73.6%)

4.6 Health Issues

Prevalence

- The 2010/11 disease registers show that the population of Canterbury and Coastal populations have a similar prevalence of diseases to that for England. With slightly greater proportion on the stroke register.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care.

- Canterbury and Coastal have higher emergency admission rates for Dementia, CHD and COPD. The trend for each of these conditions is increasing.
- Cancer emergency admissions rates are lower than Kent and Medway and continue to decline.
- Significantly higher hospital admission rate due to self harm than England.

Mortality

- 77.2% of all deaths are from three main diseases: Circulatory disease (37.2% of all deaths), Cancer (27.1% of all deaths) and respiratory disease (12.9% of all deaths).
 - Mortality rate from Circulatory disease (Coronary Heart disease and Stroke) have been steadily declining since 1995, and the rate of premature mortality is lower than that of England. The same can be said for Cancer

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5 Dartford, Gravesham and Swanley CCG

5.1 Demographics

There are 39 practices within the Dartford, Gravesham and Swanley CCG. These are located within the three districts of Dartford (16), Gravesham (16) and Sevenoaks (7).

5.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 249,935 people are registered with a practice in DGS CCGs. This is 17% of the total registered practice population for Kent.
- DGS is the second largest of the CCG, West Kent and Weald is bigger with 53 practices and 25% of the total registered Kent population.
- Combining data for Dartford and Gravesham, the population is projected to increase by 5% over the next 5 years and 11% over the next 10 years. The biggest population growth is in the 65+ (13%) and the 85+ (26%) age groups.
- Dartford and Gravesham account for just over 23% (24,900) of the total Kent County's BME population (108,000).

5.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Dartford is ranked 175 and Gravesham is ranked 142 out of 326 local authorities. Dartford is ranked 7 and Gravesham 5 of the 12 Kent districts.
- 5.2% of Dartford's and 12.7% of Gravesham's lower layer super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within, Littlebrook Joyce Green and Princes (Dartford), Singlewell, Northfleet North and Central (Gravesham).

5.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Dartford is 3.2% and Gravesham 4.2%. The rate for Kent is 3.2%.
- Unemployment in Dartford has increased by 8.1% and for Gravesham 20.2% since September 2010. The increase for Kent 13.6%.
- 18-24s make up the biggest proportion of unemployed (Dartford 31.9%, Gravesham 32.1%). The rate for Kent is 31.5%.
- 63.1% of children in Dartford (Significantly better) and 54.2% of Children in Gravesham achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 2.63% of households within Dartford (Significantly worse) and 1.83% of households in Gravesham are classified as statutory homeless; this is significantly lower than England (1.86%)

5.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Dartford (28.2%) and Gravesham (28.5%) is significantly higher than England (24.2%)
- There are significantly fewer physically active adults in Dartford (8.6%) compared to England (11.5%). The rate for Gravesham is 10.4%.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males.

Children

- There are significantly fewer physically active children in Gravesham (47.1%) compared to England (55.1%). The rate for Dartford is significantly higher at (62.0%).
- In Dartford (22.7%) the proportion of Year 6 children who are obese is significantly greater than that for England (18.7%). The rate for Gravesham is 19.9%.

5.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of DGS have a higher prevalence of hypertension, hyperthyroidism, Chronic Kidney disease and obesity, than England. T
- the population of DGS is more ethnically diverse than the rest of Kent with a larger Asian population which may go part way to explain the increased prevalence's.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- DGS has a higher emergency admission rate than Kent and Medway for Diabetes, dementia and CHD.

- The trend for CHD shows a decline in emergency admissions. Emergency admissions for the other conditions mentioned are increasing.

Mortality

73.4% of all deaths are from three main diseases: Circulatory disease (31.3% of all deaths), Cancer (28.9% of all deaths) and respiratory disease (13.1% of all deaths), within Dartford and Gravesham districts.

DRAFT

6 Maidstone and Malling CCG

6.1 Demographics

There are 11 practices within the Maidstone and Malling CCG. All but one of these practices are located within the district boundary of Maidstone, one practice is within the district boundary of Tonbridge and Malling.

6.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 99,067 people are registered with practice in M&M CCGs. This is 7% of the total registered practice population for Kent.
- M&M is one of the smallest CCGs, and has the most dispersed population, with 3 distinct communities.
- The percentage of the population within the age groups 25 to 49 is greater than that for Kent and Medway. There is a greater proportion within the 0 to 4 age group.
- Using data for Maidstone District, the population is projected to increase by 4% over the next 5 years⁴ and 9% over the next 10 years. The greatest population growth is in the 65+ (18%) and 85+ (19%) age groups.
- 6.7% of the Maidstone population are from a BME group this compares to 7.6% for Kent County.
- Life expectancy from birth for Maidstone and Malling is 81 years this compares to 80.9 for Kent and Medway. There is 7.9 years difference between the ward with the lowest life expectancy [Bridge, 76.1 years] and the ward with the highest life expectancy [Downswood and Otham 84.2 years]

6.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Maidstone is ranked 217 out of 326 local authorities and is the 9 most deprived district in Kent.
- 6.5% of Maidstone's lower layer super output areas are in the 20% most deprived for England,

6.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people

⁴ ONS 2008-Based population projections 2011-2016, 2011-2021

suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Maidstone is 2.5%, lower than the rate for Kent 3.9%.
- Unemployment in Maidstone has increased by 13% since September 2010. The increase for Kent is 13.6%.
- 18-24s make up the biggest proportion of unemployed (31.1%). The rate for Kent 31.5%.
- 65.1% of children achieve 5 A*-C grade GCSEs (including Maths and English) significantly higher than the rate for England 55.3%.
- 0.12% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

6.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%). The rate for Tonbridge and Malling is 26.1%.
- The number of admissions to hospital due to alcohol specific conditions for Maidstone and Malling CCG reduced between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Maidstone (46.2%) compared to England (55.1%). The rate for Tonbridge and Malling is 64.5%, significantly better than England.

6.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of Maidstone and Malling CCG have a higher prevalence of hyperthyroidism, than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- Maidstone and Malling population have a higher emergency admission rate than Kent and Medway for COPD, Dementia, Cancer and CHD.
- The trends for COPD and Dementia shows that emergency admissions for these conditions are increasing.

Mortality

- 75.7% of all deaths are from three main diseases: Circulatory disease (33.3% of all deaths), Cancer (27.8% of all deaths) and respiratory disease (14.5% of all deaths).

DRAFT

7 Swale CCG

7.1 Demographics

There are 20 practices within the Swale locality consortium CCG. All of these practices are located within the district boundary of Swale.

7.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 106,215 people are registered with a practice in Swale locality consortium. This is 7% of the total registered practice population for Kent.
- Swale locality group is one of the smallest CCGs.
- The population of Swale locality group is similar to that for Kent as a whole. The largest proportion of the population is in the 40-49 age group.
- Using data for Swale District, the population is projected to increase by 4% over the next 5 years⁵ and 9% over the next 10 years.
- The greatest population growth is in the 65+ (20%) and 85+ (32%) age groups
- 5.5% of the Swale population is from a BME group
- Life expectancy from birth is the lowest of all CCGs at 79.3 years. The life expectancy for Kent and Medway is 80.9 years.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes.

7.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Swale is ranked 99 out of 326 local authorities and is the 3 most deprived district in Kent.
- 20.7% of Swales lower layer super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Sheerness East, Murston and Leysdown and Warden.

7.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people

⁵ ONS 2008-Based population projections 2011-2016, 2011-2021

suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment within Swale is 3.9%, higher than the rate for Kent 3.2% and equivalent to the rate for Great Britain (3.9%)
- Unemployment in Swale has increased by 13.4% since September 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed (36.3%). The rate for Kent 31.5%.
- 53.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

7.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Swale (30.2%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males. There was a slight reduction in admissions to hospital for females between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Swale (38.9%) compared to England (55.1%)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse than England (smoking 14% Breastfeeding 73.6%)
- Teenage conception rate for Swale (46.7) is significantly higher than England (40.2)

7.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of Swale locality consortium have a higher prevalence of hypertension, Diabetes, COPD, and obesity, than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- Swale locality consortium have a higher emergency admission rate than Kent and Medway for all long term conditions (COPD, Stroke, CHD, Dementia, Diabetes and Cancer).

- For all conditions except Stroke the trend shows an increase in the rate of emergency admissions.

Mortality

- Around 75.5% of all deaths are from three main diseases: Circulatory disease (31.9% of all deaths), Cancer (28.4% of all deaths) and respiratory disease (15.2% of all deaths).

DRAFT

8 South Kent Coast CCG

8.1 Demographics

There are 33 practices within South Kent Coast, 15 of these practices are located within Dover district and 18 within Shepway district.

8.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 199,876 people are registered with a practice in South Kent Coast CCGs. This is 13% of the total registered practice population for Kent.
- The population is older than that for Kent, with fewer people under the age of 40. The largest proportion of the population is aged between 40 and 69.
- Combining the data for Dover and Shepway Districts, the population is projected to increase by 3% over the next 5 years⁶ and 7% over the next 10 years.
- The greatest population growth is in the 65+ (16%) and 85+ (12%) age groups. The age group of 0 to 4 is not projected to grow.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes.

8.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Dover is ranked 127 and Shepway is 97 ranked out of 326 local authorities and is the third most deprived district in Kent.
- 16.4% of Dover and 16.9% of Shepway's lower layer super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within St.Radigunds, Buckland and Tower Hamlets (Dover), Folkestone Harvey Central, Folkestone Harbour and Folkestone East (Shepway)

8.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

⁶ ONS 2008-Based population projections 2011-2016, 2011-2021

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Dover is 3.7% and Shepway 4.2%. The rate for Kent is 3.2%.
- Unemployment in Dover has increased by 25.2%, the greatest increase of the 12 Kent districts, this contrasts with an 11.5% increase in Shepway since September 2010. The increase for Kent is 13.6%
- 18-24s make up the biggest proportion of unemployed (Dover 32.1%, Shepway 28.3%). The rate for Kent is 31.5%.
- 50.3% of children in Dover and 52.3% of children in Shepway achieve 5 A*-C grade GCSEs (including Maths and English) significantly lower than the rate for England 55.3%.
- 1.35% of households within Dover (significantly lower) and 1.82% of Households in Shepway are classified as statutory homeless; both are lower than England (1.86%)

8.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Dover (26.8%) is significantly higher than England (24.2%). The rate for Shepway 25.9%.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year for South Kent CCG.

Children

- There are significantly fewer physically active children in Shepway (48.3%) compared to England (55.1%). The rate for Dover is (63.9%) which is significantly more than England.
- Teenage conception rate for Shepway (46.6) is significantly higher than the rate for England (40.2). The rate for Dover is (36.4)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse than England (smoking 14% Breastfeeding 73.6%)

8.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of SKC have a higher prevalence of CHD, stroke, Hypertension, Diabetes, Epilepsy, Hypothyroidism, Cancer, Atrial Fibrillation and learning disabilities when compared to England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- South Kent Coast have a higher emergency admission rate than Kent and Medway for all long term conditions (COPD, Stroke, CHD, Dementia and Diabetes), except Cancer..
- For all conditions except Cancer the trend shows an increase in the rate of emergency admissions.

Mortality

76.3% of all deaths are from three main diseases: Circulatory disease (34.2% of all deaths), Cancer (27% of all deaths) and respiratory disease (15% of all deaths).

DRAFT

9 Thanet and East Cliff CCG

9.1 Demographics

There are 21 practices within Thanet CCG all of these practices are located within the district of Thanet.

9.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 140,563 people are registered with a practice in Thanet CCG. This is 9.4% of the total registered practice population for Kent.
- Thanet has fewer people aged between 20 and 49 compared to Kent and Medway.
- Using data for Thanet District, the population is projected to increase by 3% over the next 5 years⁷ and 7.6% over the next 10 years.
- The greatest population growth is in the 65+ (13%) and 85+ (9%) age groups
- 7% of the Thanet population are from a BME group, this compares to 7.6% for Kent County.
- Life expectancy from birth is 79.6 years this is the second lowest of all the CCGs. There is 12.1 years between the ward with the lowest life expectancy [Cliftonville West 72.3 years] and the ward with the greatest life expectancy. [Kingsgate 84.4 years]

9.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Thanet is ranked 49 out of 326 local authorities and is the 1 most deprived district in Kent.
- 29.8% of Thanet's lower layer super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Margate Central, Cliftonville West and East Cliffe.

9.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

⁷ ONS 2008-Based population projections 2011-2016, 2011-2021

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment with Thanet (5.8%) is the greatest of all the 12 districts in Kent. The rate for Kent is 3.2%.
- Unemployment in Thanet has increased by 16.8% since September 2010. The increase for Kent is 13.6%
- 18-24s make up the biggest proportion of unemployed (32.5%). The rate for Kent 31.5%.
- 49.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Thanet are classified as statutory homeless; this is lower than England (1.86%)

9.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults, physical activity, and smoking are significantly higher for Thanet compared to England.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year.

Children

- There are significantly fewer physically active children in Thanet (51%) compared to England (55.1%)
- Teenage conception rate for Thanet (51) is significantly higher than that for England (40.2)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse than England (smoking 14% Breastfeeding 73.6%)

9.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of Thanet have a higher prevalence for most conditions recorded on primary care disease registers, with the exception of Asthma, Heart failure and Depression.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- Thanet CCG has a higher emergency admission rate than Kent and Medway for Diabetes, COPD, CHD and Stroke.
- The emergency admission rate for Dementia is lower. The trend shows an increase.
- The trend for Cancer emergency admissions shows a decline.

Mortality

- Around 75.3% of all deaths are from three main diseases: Circulatory disease (33.6% of all deaths), Cancer (26.5% of all deaths) and respiratory disease (15.1% of all deaths)

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10 West Kent and Weald CCG

10.1 Demographics

There are 53 practices within the West Kent and Weald CCG. These are located within the four districts of Maidstone (14), Sevenoaks (7), Tonbridge and Malling (11) and Tunbridge Wells(21). Dr Winch has branch surgery located in Biddenden within the district of Ashford.

10.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- WKW is the largest off the 8 Kent CCGs, with a registered practice population of 366,974, which is 25% of the total registered population for Kent.
- The proportion of the population aged between 20 to 35, there is a peak in the 0 to 20 years olds, which may have implications for deliver of services to the young population.
- Combining data for the 4 districts the population of WKW is projected to increase by 4% over the next 5 years and by 9% over the next 10 years
- The greatest population growth is in the 65+ (18%) and 85+ (19%) age groups
- 6.8% of the population are from a BME group, compared to 7.6% for Kent County
- Life expectancy is 82.3 years compared to 80.9 for Kent and Medway, the population of WKW is highest of all the CCGs. The difference in life expectancy between wards within the four districts is 16.9 years. Both the highest life expectancy and the lowest life expectancy are for wards within Tonbridge and Malling District. [Kings Hill 92 years, Bumham, Eccles and Wouldham 75,1 years]

10.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- The CCG of West Kent and Weald spans 4 districts. These 4 districts have the lowest levels of deprivation for Kent ranked between 9 and 12. Sevenoaks has the lowest levels of deprivation across Kent and with Tonbridge and Malling falling within the 20% least deprived districts in England.
- Two districts (Tonbridge & Malling and Tunbridge Wells) have no lower layer super output areas in the 20% most deprived for England, 1.4% of Sevenoaks and 6.5% of Maidstone lower layer super output areas are in the 20% most deprived for England.

10.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment for each of the 4 districts, Maidstone (2.5%), Sevenoaks (1.8%), Tonbridge and Malling (2.0%) and Tunbridge Wells (1.8%), have lower levels of unemployment of Kent (3.2%)
- Unemployment has increased by 13% (Maidstone), 7.3% (Sevenoaks), 11% (Tonbridge and Malling) and 2.4% (Tunbridge Wells) since September 2010. The increase for Kent is 13.6%.
- 18-24s make up the biggest proportion of unemployed (Maidstone 31.1%, Sevenoaks 27.8%, Tonbridge and Malling 30.2% and Tunbridge Wells 23.7%). The rate for Kent 31.5%.
- For three of the districts children achieving 5 A*-C grade GCSEs (including Maths and English) ranging from 61.2% to 71% have rates that a significantly higher when compared to 55.3% for England. Sevenoaks however at 38.7% is significantly worse than the rate for England
- All four districts have significantly lower rate of households classified as statutory homeless ranging from 0.12% to 1.06%. The rate for England is 1.86%

10.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%) the prevalence of adult obesity in the other districts are generally not significantly different or are significantly lower.
- The number of admissions to hospital due to alcohol specific conditions declined between 2009/10 and 2010/1

Children

- There are significantly fewer physically active children in Maidstone (46.2%) compared to England (55.1%)

10.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of WKW have a higher prevalence of Stroke, hyperthyroidism, and Cancer than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- WKW has an emergency admission rate higher than Kent and Medway for Cancer, and the trend continues to decline.
- Emergency admission rates are increasing for Dementia, COPD and CHD.
- Stroke and Diabetes emergency admission rates are reducing.

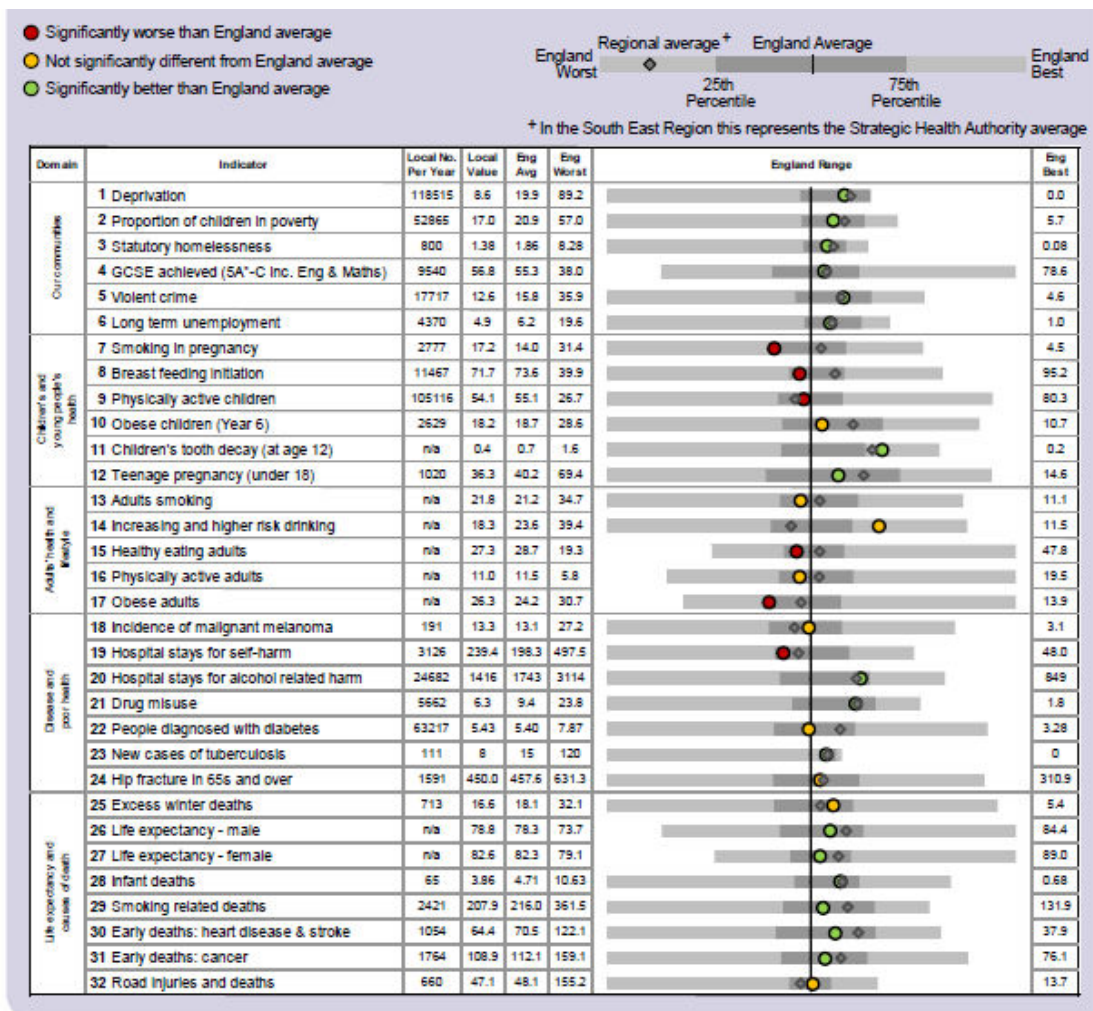
Mortality

- Around 76.5% of all deaths are from three main diseases: Circulatory disease (34.3% of all deaths), Cancer (28.6% of all deaths) and respiratory disease (13.6% of all deaths).

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Appendix B – Health Profiles 2011

Kent County Council

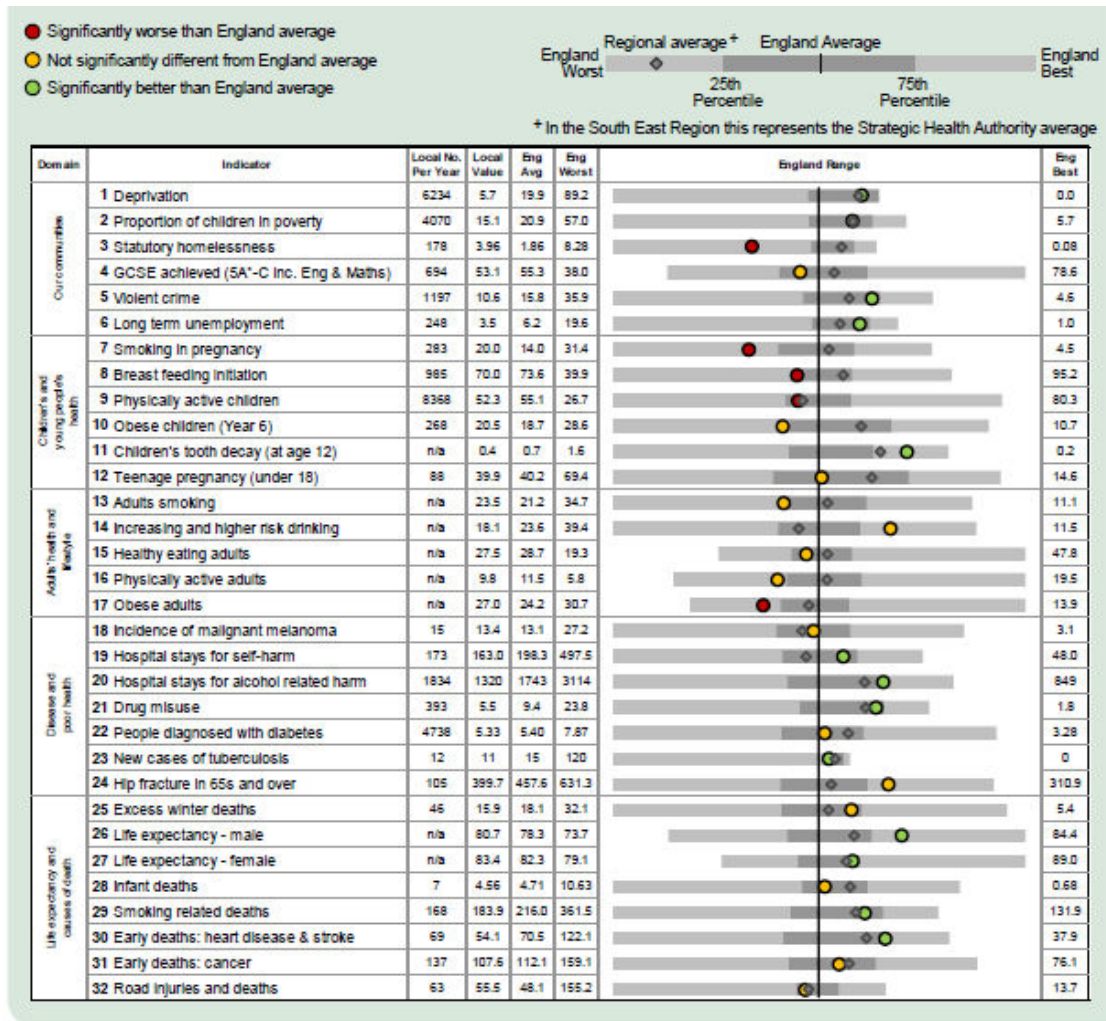


Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2006 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged 16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 16+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35+, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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Ashford

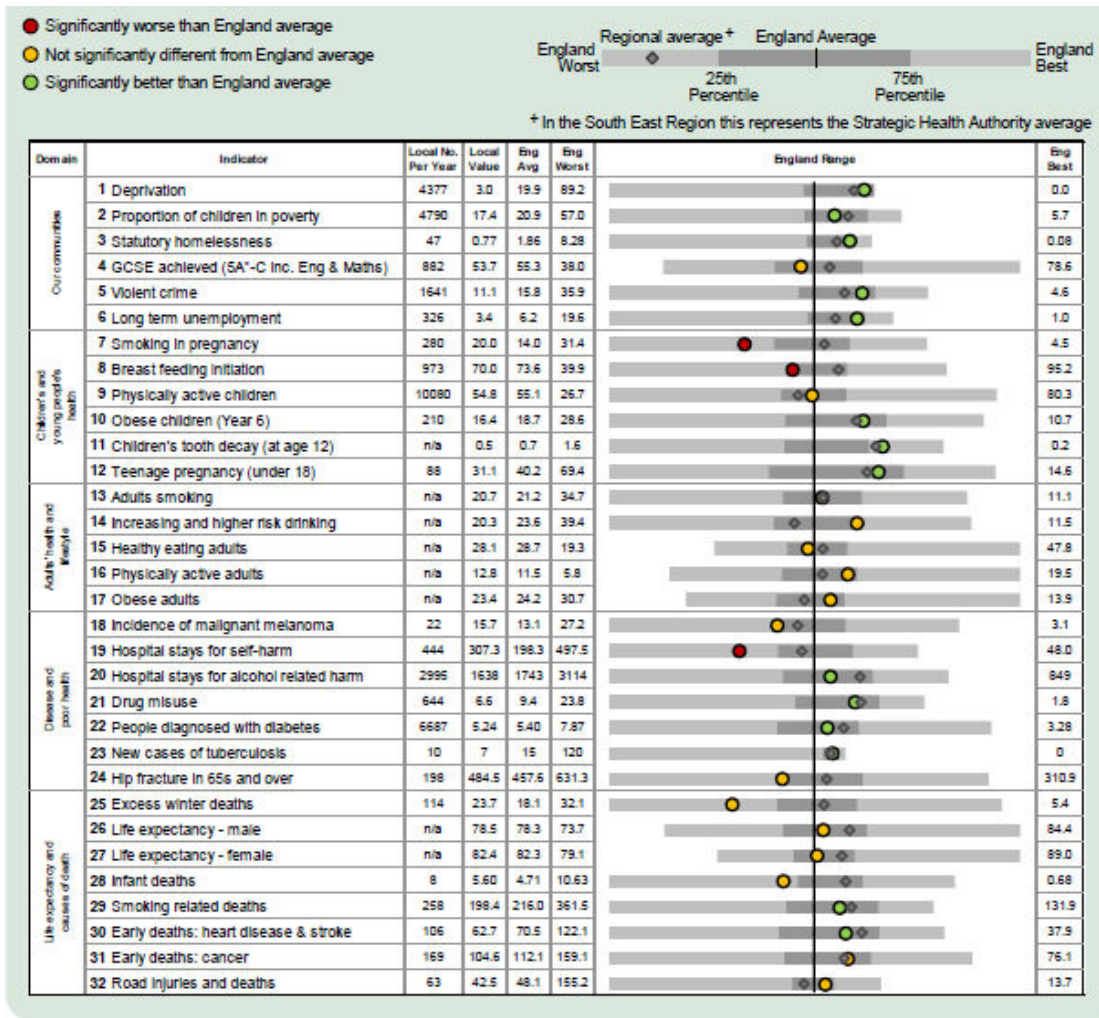


Indicator Notes

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Canterbury

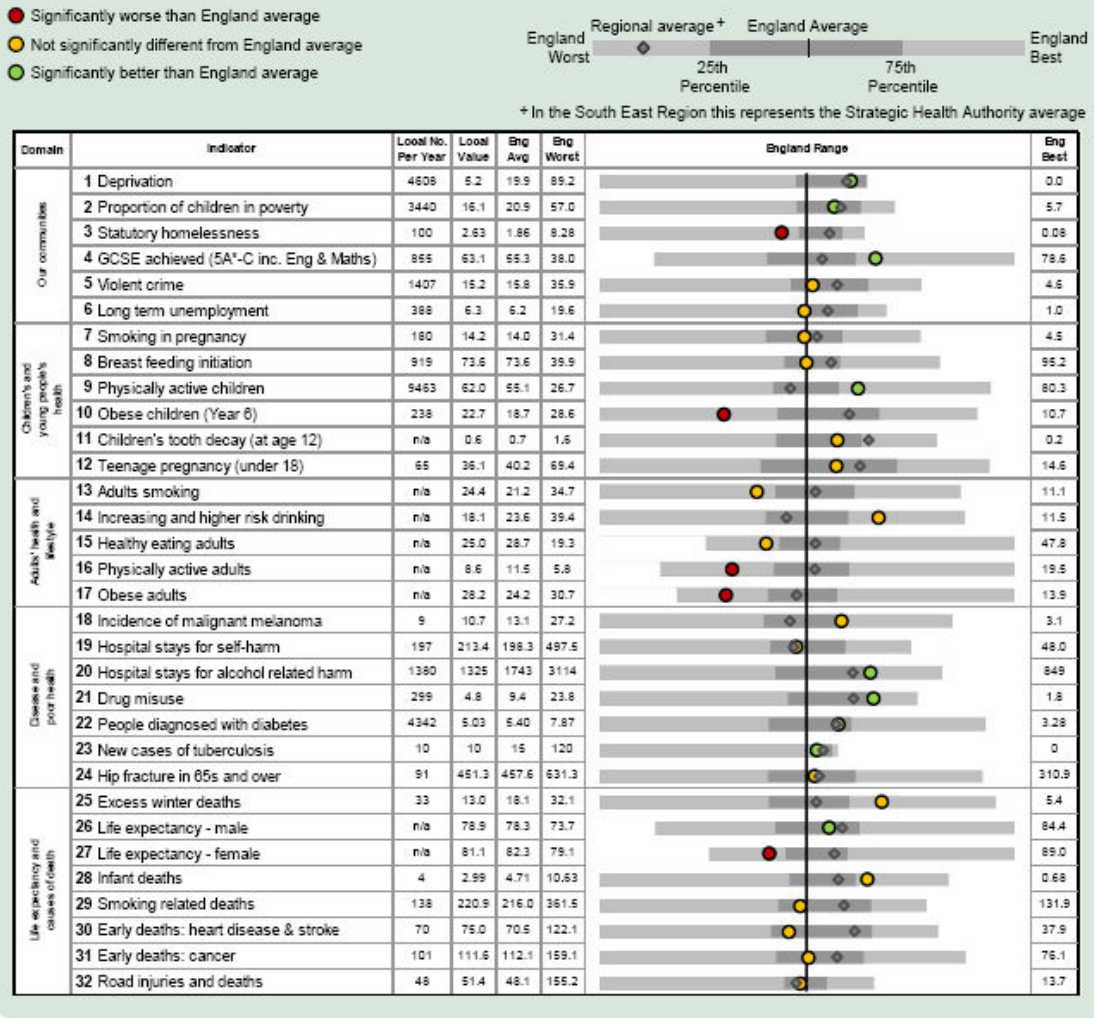


Indicator Notes

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For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Dartford

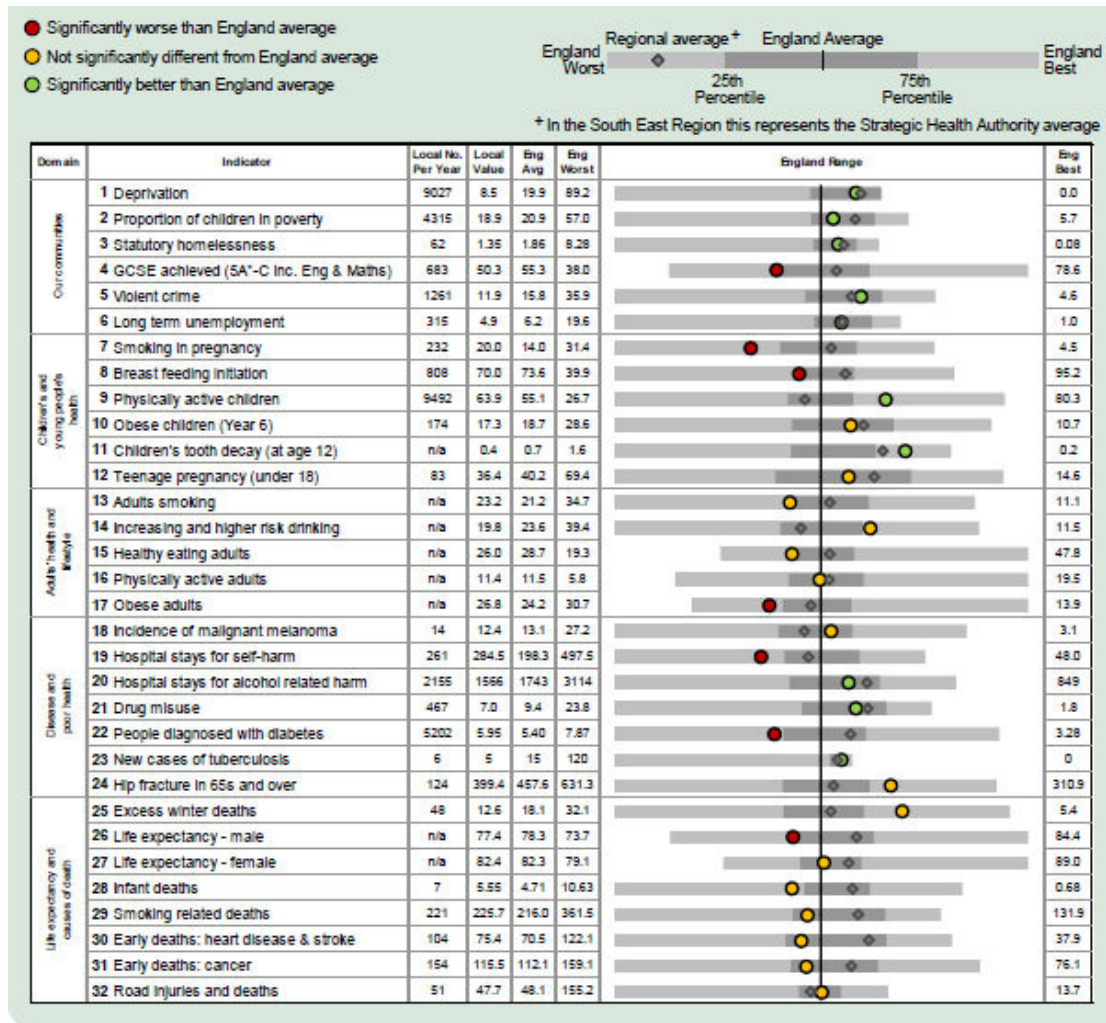


Indicator Notes

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Dover

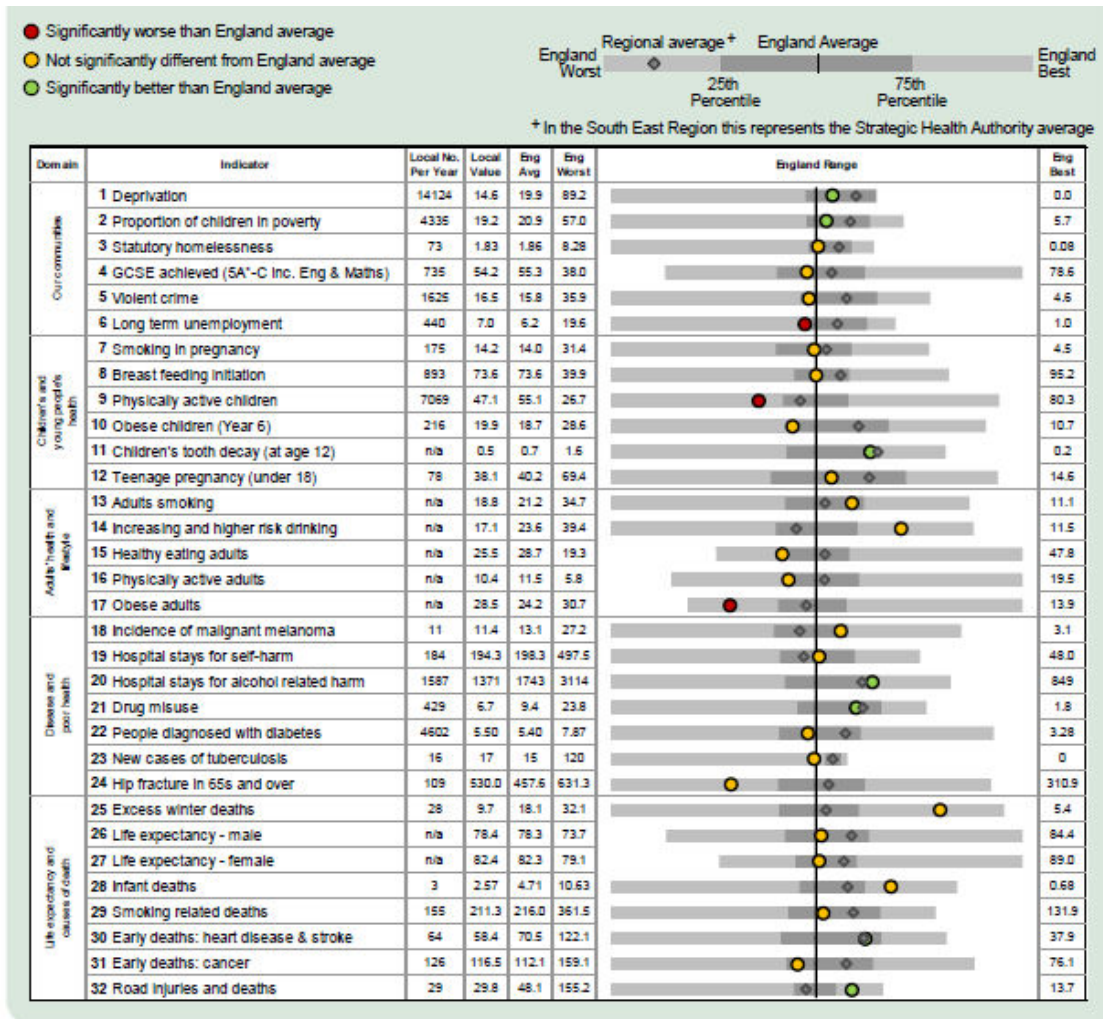


Indicator Notes

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Gravesham

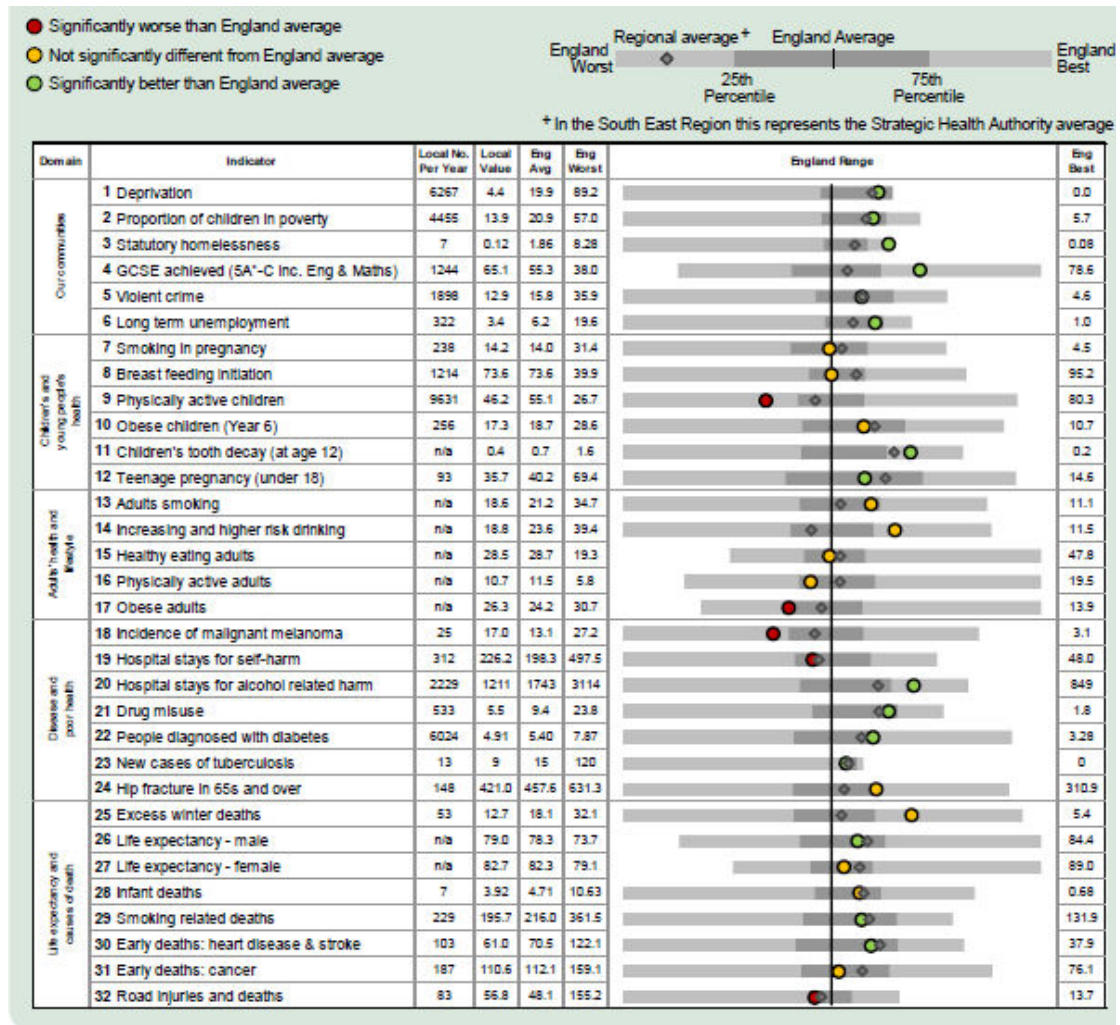


Indicator Notes

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For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Maidstone

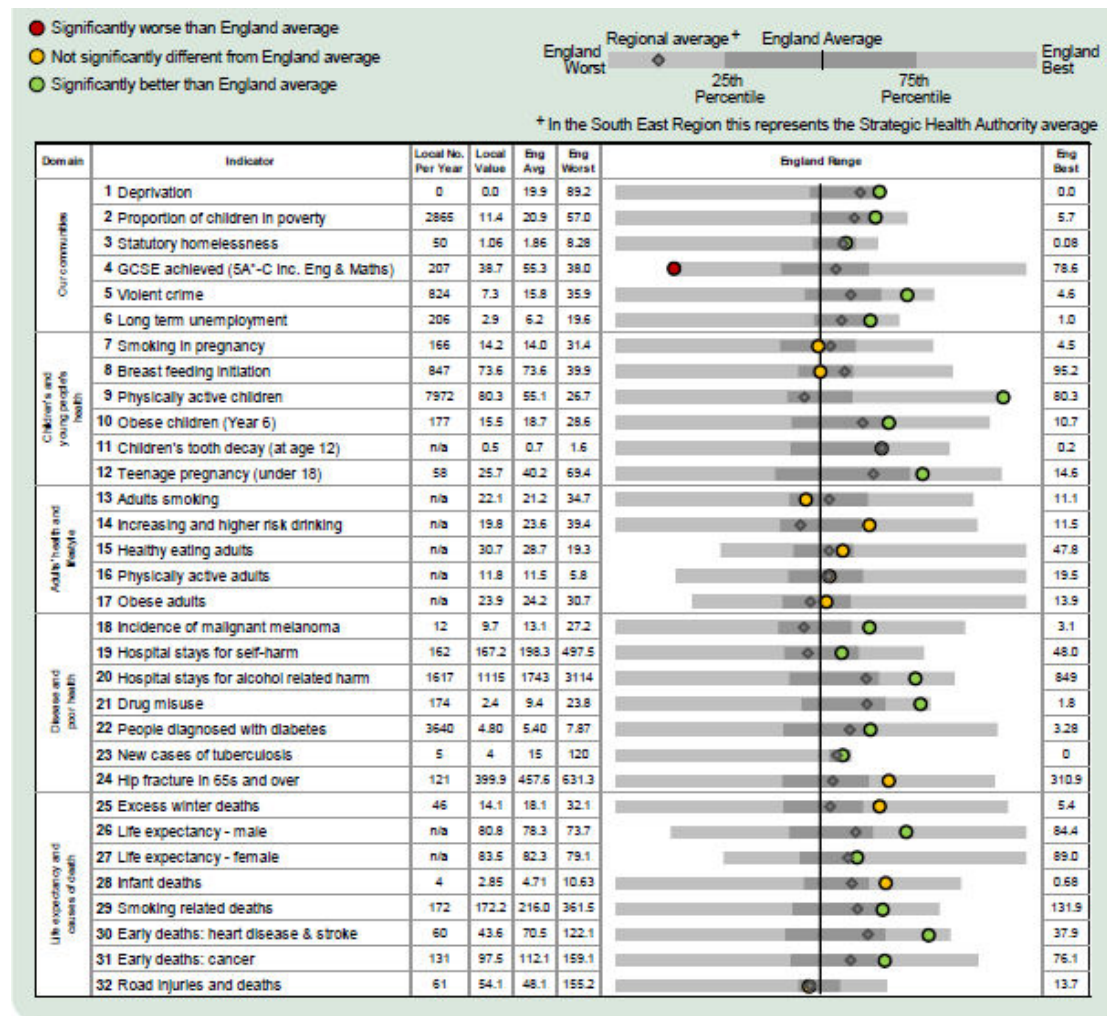


Indicator Notes

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Sevenoaks

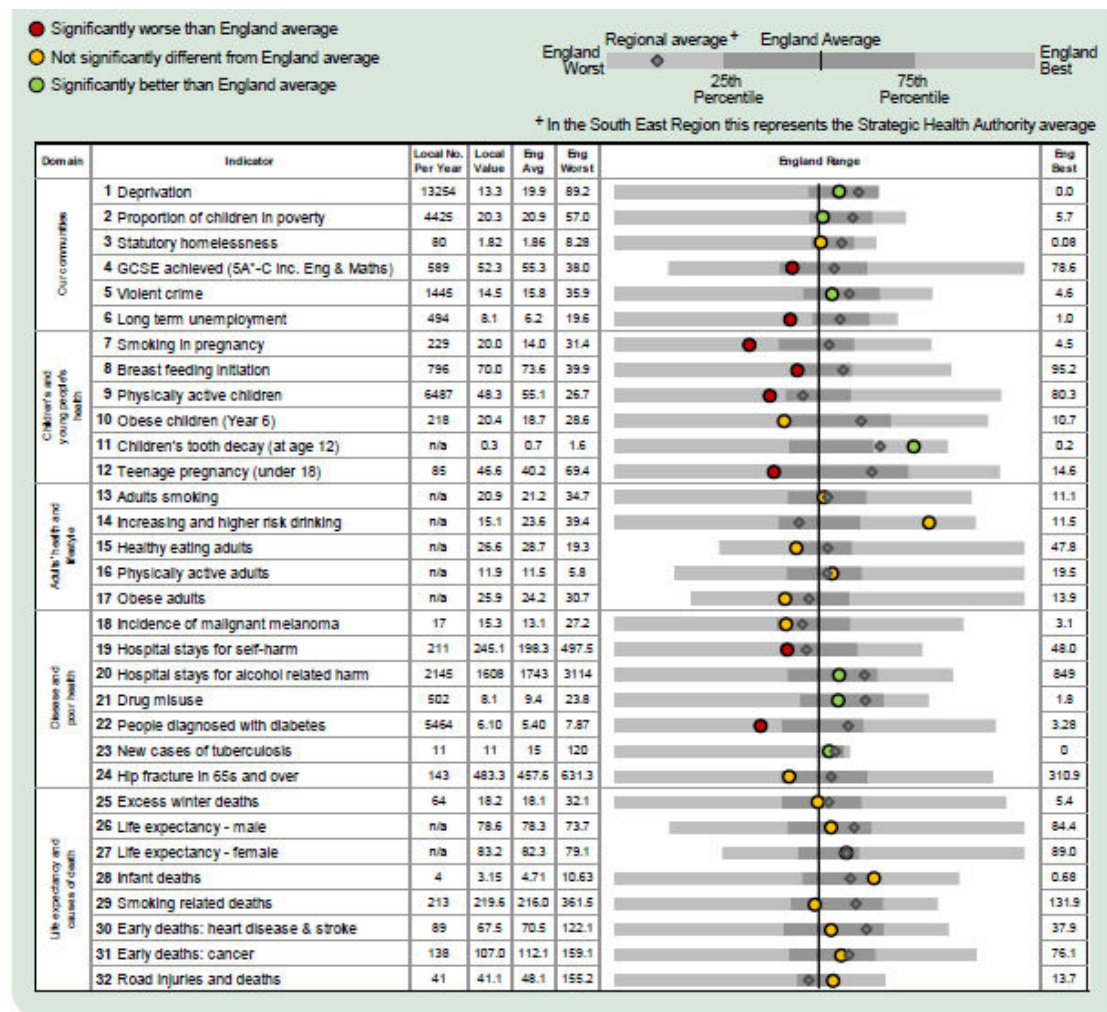


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Shepway

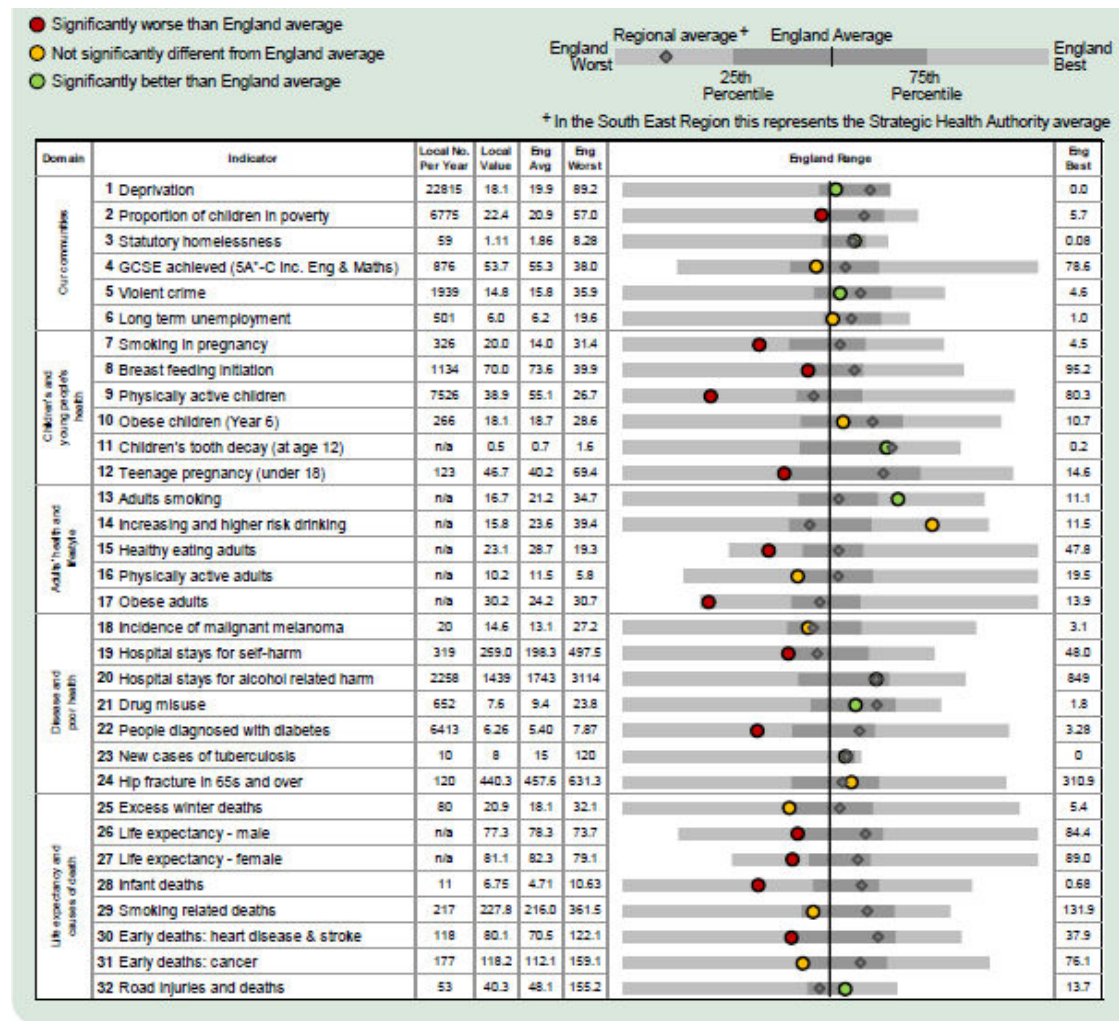


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Swale

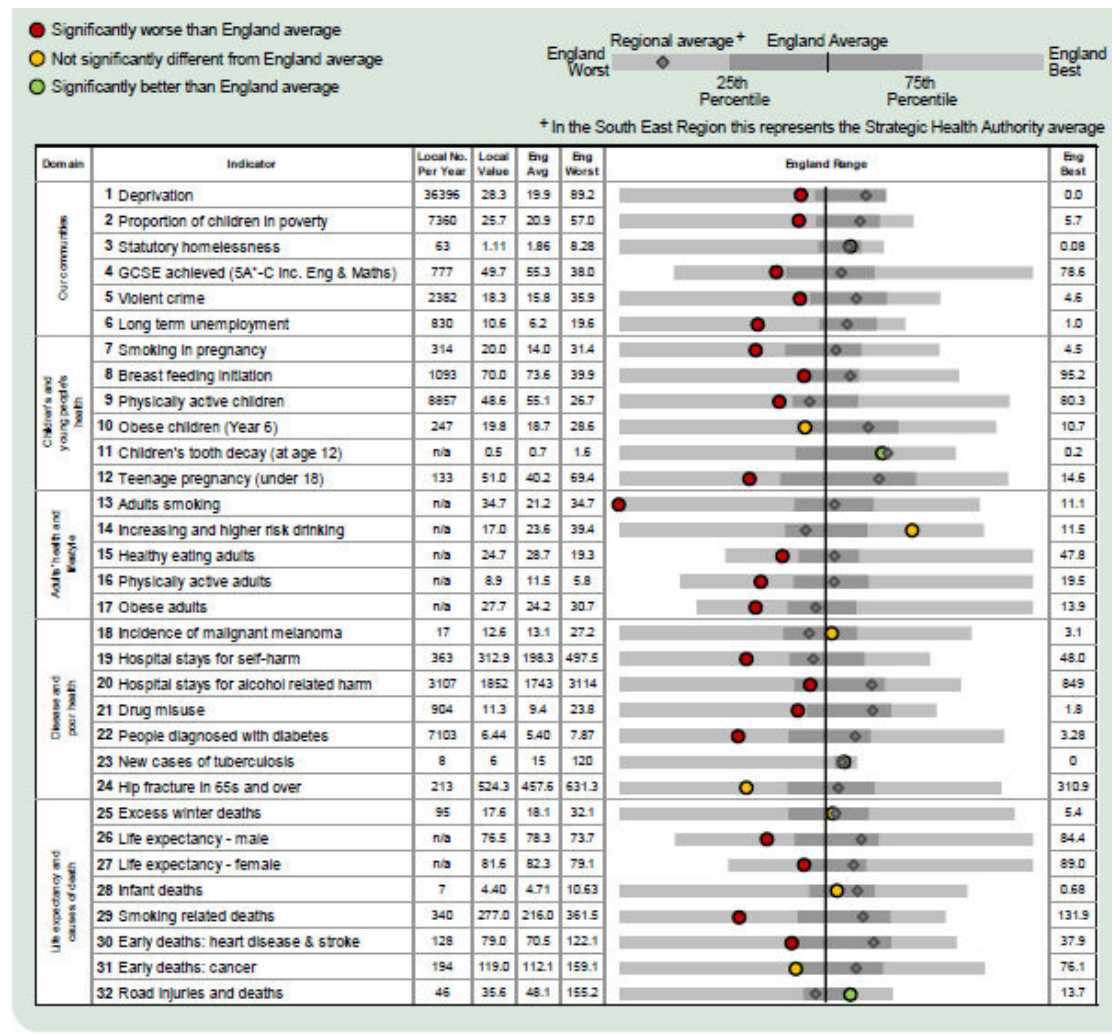


Indicator Notes

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Thanet

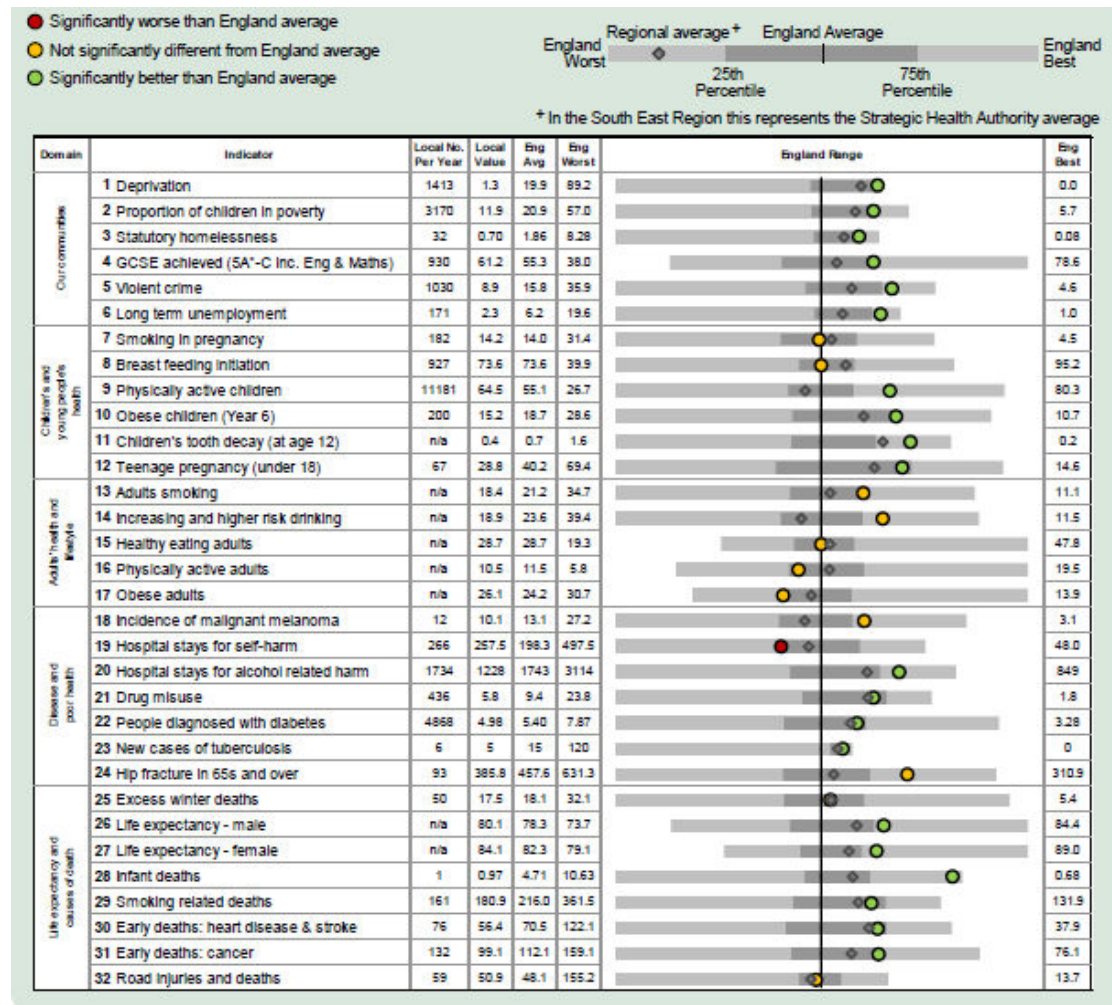


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Tonbridge and Malling

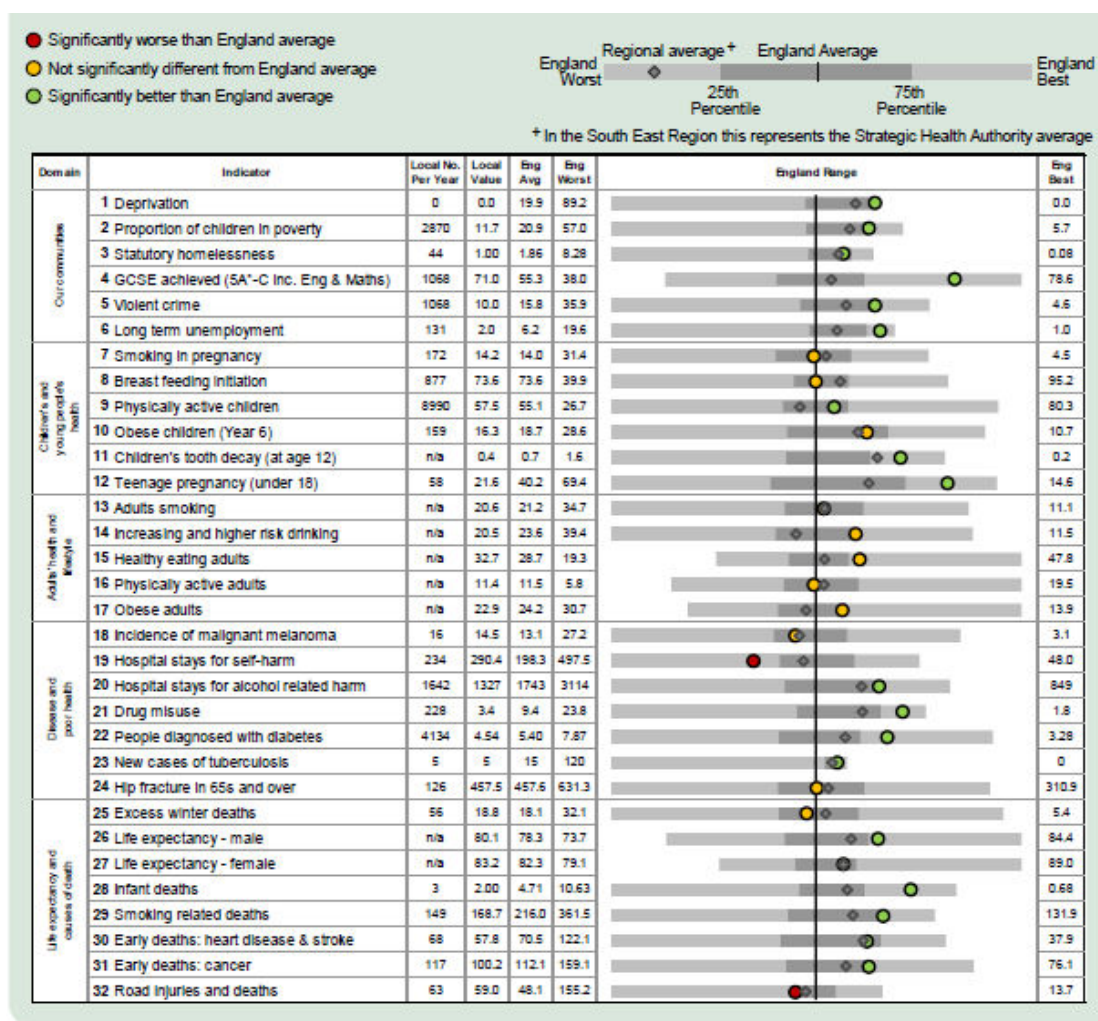


Indicator Notes

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Tunbridge Well



Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged 16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 16+, 2009/10 14 % aged 16+ in the resident population, 2008/09 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35+, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More Indicator information is available online in The Indicator Guide.

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
 Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **STRATEGIC COMMISSIONING AND THE TRANSFORMATION OF ADULT SOCIAL CARE**

Classification: Unrestricted

Summary: KCC is expecting to have to make savings of up to £200m between 2012 and 2015. A significant portion of this will need to be found from within Adult Social Care.

Savings of this magnitude will only be achieved through transformation. This requires a high level review of how social care is currently delivered. Service redesign will be achieved by focussing on many key activities at the same time. It will be fundamental to understand the relationship and interdependencies of these key activities and ensure that they are done well and within required timescales.

The vision for 2015 needs to be coproduced between partners, providers, users and carers. This will ensure we achieve innovative solutions, and importantly ownership of the challenge we face. As a local authority we can unilaterally cut services but we can only transform them with the full engagement of stakeholders.

The Adults' Transformation Programme will be how Families and Social Care (FSC) will contribute to the delivery of 'Bold Steps for Kent'. Preparations for implementing the Transformation Programme need to start now.

Introduction

1. (1) KCC is expecting to have to make budget savings of up to £200m between 2012 and 2015. Cabinet and the Corporate Management Team (CMT) have been considering how this can be achieved and details will be published in the draft Budget and Medium Term Financial Plan (MTFP)

(2) A significant proportion of the savings will need to be found from within Adult Social Care. This paper sets out how Strategic Commissioning and the Transformation Programme for Adult Social Care will support the delivery of the required savings.

Bold Steps for Kent Delivery Framework

2. (1) This transformation strategy will support the delivery of the following Bold Steps:
- Priority 1: Improve how we procure and commission services
 - Priority 2: Support the transformation of health and social care in Kent
 - Priority 7: Build a strong relationship with key business sectors across Kent
 - Priority 9: Support new housing growth that is affordable, sustainable and with the appropriate infrastructure
 - Priority 11: Improve access to public services and move towards a single initial assessment process
 - Priority 12: Empower social service users through increase use of personal budgets
 - Priority 13: Establish a Big Society Fund to support new social enterprise in Kent
 - Priority 14: Ensure the most robust and effective public protection arrangements
 - Priority 15: Improve services for the most vulnerable people in Kent
 - Priority 16: Support families with complex needs and increase the use of community budgets

Existing Medium Term Financial Plan (MTFP) requirements

3. (1) There are savings of £21m already identified within the MTFP 2011 - 2013, of which £10m is intended in 12/13. The focus to date has been on achieving short term efficiencies. Savings of £5.5m are intended to be delivered during 2012/13 by reducing prices for Domiciliary Care and Learning Disability placements.

Strategic Commissioning Approach

4. (1) It will not be possible to continue to focus on short term price reductions. If this were to be pursued the required savings will not be achievable, sectors of the social care market would be at risk of failure, and during the term of the MTFP service cuts would be required to balance the budget.

(2) The existing approach to delivering efficiencies has been through the production of Project Initiation Documents (PIDs). This has been largely successful however some PIDs have not been based upon sound business cases and wider connections with other service areas have not been made. Clearly evidenced cause and effect is also a major issue, with achieved savings not easily attributable to specific actions.

(3) Savings of the magnitude that will be needed will only be achieved through transformation. This requires a high level review of how social care is currently delivered. Service redesign will be achieved by focussing on many key activities at the same time. It will be fundamental to understand the relationship and interdependencies of these key activities and ensure that they are done well and within required timescales.

Transformation Programme

5. (1) Savings will be achieved by either paying less, buying less or buying cheaper alternatives. We need to work hard to ensure that people are in the right place for the right length of time and at the right cost. When considering options we will consider the following themes; demand management, localism, incentivisation and personalisation.

(2) Savings of the order of magnitude needed will only be achieved if we radically change the current investment profile. Transformation will be the result of the combined affect of many activities, which are done well and at the right time.

(3) Currently 53% of net expenditure on services is in relation to care home placements. We need to create a vision for 2015 which is based upon a new investment profile within a significantly reduced budget.

(4) The vision for 2015 will be based upon adding maximum value by working with NHS and other statutory partners; a real focus on prevention and targeted intervention; ensuring services respond rapidly; supporting carers and individuals to do more for themselves; a new deal with both voluntary and independent providers based upon trust and incentivisation; daring to let go of things that we currently do ourselves.

(5) The vision for 2015 needs to be coproduced between partners, providers, users and carers. This will ensure we achieve innovative solutions, and importantly ownership of the challenge we face. As a local authority we can unilaterally cut services but we can only transform them with the full engagement of stakeholders.

Indicative Workstreams / Projects

6. (1) The transformation programme will have numerous workstreams with many key activities. It is essential that focus is maintained on delivery. These indicative workstreams will be further developed through engagement with stakeholders. The 7 key indicative workstreams are set out below:

(2) **A: Advice and information and preventative services**

- A.1 Provide really good advice and information and signpost people to alternative services
- A.2 Develop a range of targeted preventative services that achieve desired outcomes
- A.3 Encourage the voluntary sector to work more closely together, sign posting to each others' services and considering sharing overheads and management costs
- A.4 Identify things that the voluntary sector can do instead of KCC
- A.5 Assist the voluntary sector in different ways (property and ICT)
- A.6 Identify services that are marketable and develop social enterprises
- A.7 Consider ways of managing demand by forging closer links with organisations providing financial products for self funders

(3) **B: Support for users and carers**

- B.1 Encourage people to do more for themselves
- B.2 Respond rapidly and offer greater support to carers at points of crisis
- B.3 Make better use of community networks and incentivise volunteering

(4) **C: Assessment and enablement**

- C.1 Reconsider eligibility for services and the 'offer' (resource allocation system)
- C.2 Ensure that transition arrangements are as efficient and effective as possible
- C.3 Create 'access to resources' function to ensure that every penny counts
- C.4 Reorganise assessment and care management teams to focus on prevention and enablement
- C.5 Work closely with GP's and primary care to focus more on long term conditions to improve people's ability to self care
- C.6 Ensure sufficient capacity of well trained enablement facilitators working with FSC assessment and care management staff, NHS staff and independent providers
- C.7 Ensure that enablement is fully linked to telecare and the provision of equipment
- C.8 Respond rapidly to prevent hospital admissions, allow GP's to directly contact enablement services, work closely with the ambulance service
- C.9 Discharge majority of people from hospital to be assessed therefore requiring less social workers in hospital and more in the community aligned to primary care

(5) **D: Care homes**

- D.1 Continue to negotiate on price for Learning Disability, Mental Health and Physical Disability placements and ensure that any new placements are Value For Money
- D.2 Understand reasons why people are admitted to care homes, who really needs to be there and what admissions can be avoided i.e. (Incontinence; greater support for carers)
- D.3 Consider helping providers in different ways (utilities, equipment, and capital)
- D.4 Incentivise care homes to get more people home
- D.5 Make best use of care home resources, use beds flexibly, focus on more specialist services, dementia, intermediate care, end of life

(6) **E: Housing**

- E.1 Ensure people with the right level of dependency are offered and access supported housing
- E.2 Produce an accommodation strategy and market position statements to clearly show current availability and what is required in the future
- E.3 Work with housing providers to develop a range of housing solutions as an alternative to residential care

- E.4 Ensure people with a disability can access accommodation that is adapted to meet their individual needs and that we make the best use of technology

(7) **F: Domiciliary care and community support**

- F.1 Develop key strategic partnerships with providers who have sufficient volume
- F.2 Broker relationship between the key strategic partner and the individual
- F.3 Allow key strategic partners and individuals to amend services within parameters through introducing trusted assessor status and individual service funds
- F.4 Incentivise key strategic partners to work with voluntary sector providers and micro businesses
- F.5 Develop specialist services if required

(8) **G: Day opportunities**

- G.1 Review day opportunities to maximise efficiencies.

Governance and resources

7. (1) A programme manager will be identified for the duration of the transformation programme reporting to the Director of Strategic Commissioning as Programme Sponsor.

(2) The Strategic Commissioning Division within FSC will be restructured. It will work closely with Strategic Procurement, to introduce category management which will drive the delivery of the transformation programme. Formal consultation with staff on the proposed new structure will commence mid January. Consideration needs to be given to the resources required within the restructured commissioning teams.

(3) The 3 month period January – March 2012 will be used to plan the detail of the transformation programme. This will involve events with staff, members, providers and other stakeholders. Workstreams will be developed and costed and presented to the Budget Programme Board (assurance) and the Procurement & Commissioning Board (delivery). We need to quickly start the transformation process but we must be thorough as we move through the phases of transformation.

Transfer of NHS funding

8. (1) The Operating Framework for the NHS in England 2011/12 outlines the transfer of £648m in 2011/12 and £622m in 2012/13 NHS funding to Local Authorities to support social care. The funding transferred is required to be used to invest in social care activities to benefit health, and to improve overall health gain. The Kent allocation of NHS funding to be transferred is £16.2m in 2011/12 and £15,656,000 in 2012/13.

(2) The £16.2m allocation for 2011/12 is committed against existing services that support health outcomes as well as the development of new services in the following areas:

- Dementia (£1.4m)
- Advanced Assistive Technology (£1.2m)
- Early access, assessment and integrated Working (£3.3m)
- Reducing non-elective activity including acute length of stay (£5m)
- Winter pressures (£4m)
- Locality commissioning (£1.1m)
- Carers (£0.2m)

(3) During the 3 month period January – March 2012 we will work up detailed proposals for investment during the early part of the transformation programme against the £15.7m 2012/13 allocation.

Recommendations

9. (1) Members are asked to NOTE the proposed development of a Transformation Programme for Adult Social Care and the role of Strategic Commissioning in delivering this.

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Background documents: None

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview & Scrutiny Committee – 10 January 2012

Subject: **INTERIM REPORT OF FORMAL CONSULTATION ON A NEW SERVICE MODEL FOR LEARNING DISABILITY DAY SERVICES IN THE SHEPWAY DISTRICT**

Classification: Unrestricted

Summary: This report provides the Adult Social Care and Public Health Policy Overview & Scrutiny Committee with an interim account of the formal consultation that is currently underway on a new service model for learning disability day services in Shepway.

Introduction

1. (1) A fourteen week formal consultation period on a New Service Model for Shepway Learning Disability Day Services commenced on 22 November 2011; with a series of consultation meetings held for the main stakeholders. Although the consultation process is in the early stages, 8 completed questionnaires have been received.

(2) In line with “Valuing People Now” and KCC’s “Active Lives” and “Bold Steps” the New Service Model for future services will be based on personalisation, with everyone having choice and control over the shape of their support through the use of direct payments and personal budgets. This person centred approach will uphold the principles and standards of the Good Day Programme.

The principles for the new service model are to develop services which will enable people to:

- Choose what they do during days, evenings and weekends
- Have the right flexible support
- Be equal citizens in their community
- Have opportunities to lead a full and meaningful life.

The new service model will offer people a range of facilities, activities and opportunities in their local community within inclusive settings.

Full details of the proposed New Service Model for Learning Disabilities Day Services in Shepway are detailed in (Appendix 1)

Formal Consultation

Process

2. (1) Consultation packs have been distributed to 420 stakeholders including, Service Users, parent/family carers, guardians, independent living scheme managers, local businesses, local providers (voluntary and private sector), professional carers, the local MP, KCC Members and Shepway District Councillors, staff and unions.

The consultation pack contains:

- The proposal for the New Service Model
- A Consultation Questionnaire
- Copy of the presentation delivered at the consultation meetings.
- Timetable of consultation meetings and events.
- Better Days leaflet - setting out the principles and aims of the Good Day Programme

(2) An additional reminder letters to encourage people to feedback their comments and views will be sent out 2 weeks prior to the close of the consultation period on 13 February 2012.

(3) The consultation project team are recording all enquiries, comments, risks and concerns' regarding the consultation to ensure all information is captured. In addition, a comprehensive series of communication activities will continue throughout the consultation period to ensure all stakeholders are able to contribute fully (please see table below).

Communication Activities

Consultation Launch Event	22 November 2011
Other Stakeholders Event	29 November 2011
Information Road Shows	7 December 2011
	12 January 2011
	6 February 2012
One to One Meetings	Available throughout the consultation period
Shepway District Partnership Group Presentation	5 December 2011
	12 February 2012
Staff meetings	Throughout the consultation period.
Voiceability (Service User advocacy) Workshops, Group and one to one meetings.	23 November 2011 to 28 February 2012
On line information available at: kent.gov.uk/learningdisability	22 November 2011 to 28 February 2012
Reminder letters for close of consultation	13 February 2012
Close of consultation	28 February 2012

Core themes emerging from consultation

3. (1) Family Carers

- Requested reassurance Service Users attending the new community hubs will be looked after in the same way as before e.g. if a family/carer is late picking up a service user, would the same protocols be put in place to ensure the person is in a safe environment.
- Assurance transport will be sustained to access community facilities
- Family/carers attending the launch event said the initial work with Service Users that attend The Bridge Resource Centre and community activities has been very successful.

(2) Service users

- Voiceability (advocacy service) commenced working with Service Users on 23 November 2011 to ensure they fully understood the processes and the consultation meaning.
- Voiceability will deliver an interim report by 23 December 2011.

(3) Staff

- General HR enquiries have been raised regarding employment continuity
- Staff want assurance all the work with Service Users person centred planning will be sustained to ensure people have full access to a variety of community activities.

(4) Other Stakeholders/providers

- Local businesses surrounding the Shepway Resource Centre have not responded to the consultation to date
- Local providers have expressed an interest in finding out more about how the new community hubs will be upgraded and how local providers can be supported to deliver community activities in the future.

Conclusion

4. (1) The formal consultation period on a New Service Model for Shepway Learning Disability Day Services ends on 28 February 2012. All views and comments will be gathered and responses brought together in a report. This report will be presented to Adult Social Care and Public Health Policy Overview & Scrutiny Committee for consideration and the Cabinet Member for Social Care and Public Health will be asked to approve the implementation of the new service model.

Recommendations

5. (1) Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to NOTE the feedback gained to date during the consultation.

Background documents: None

Appendix 1 - Shepway Learning Disability Day Services Consultation Document

Appendix 2 – Shepway Learning Disability Day Services Consultation Questionnaire

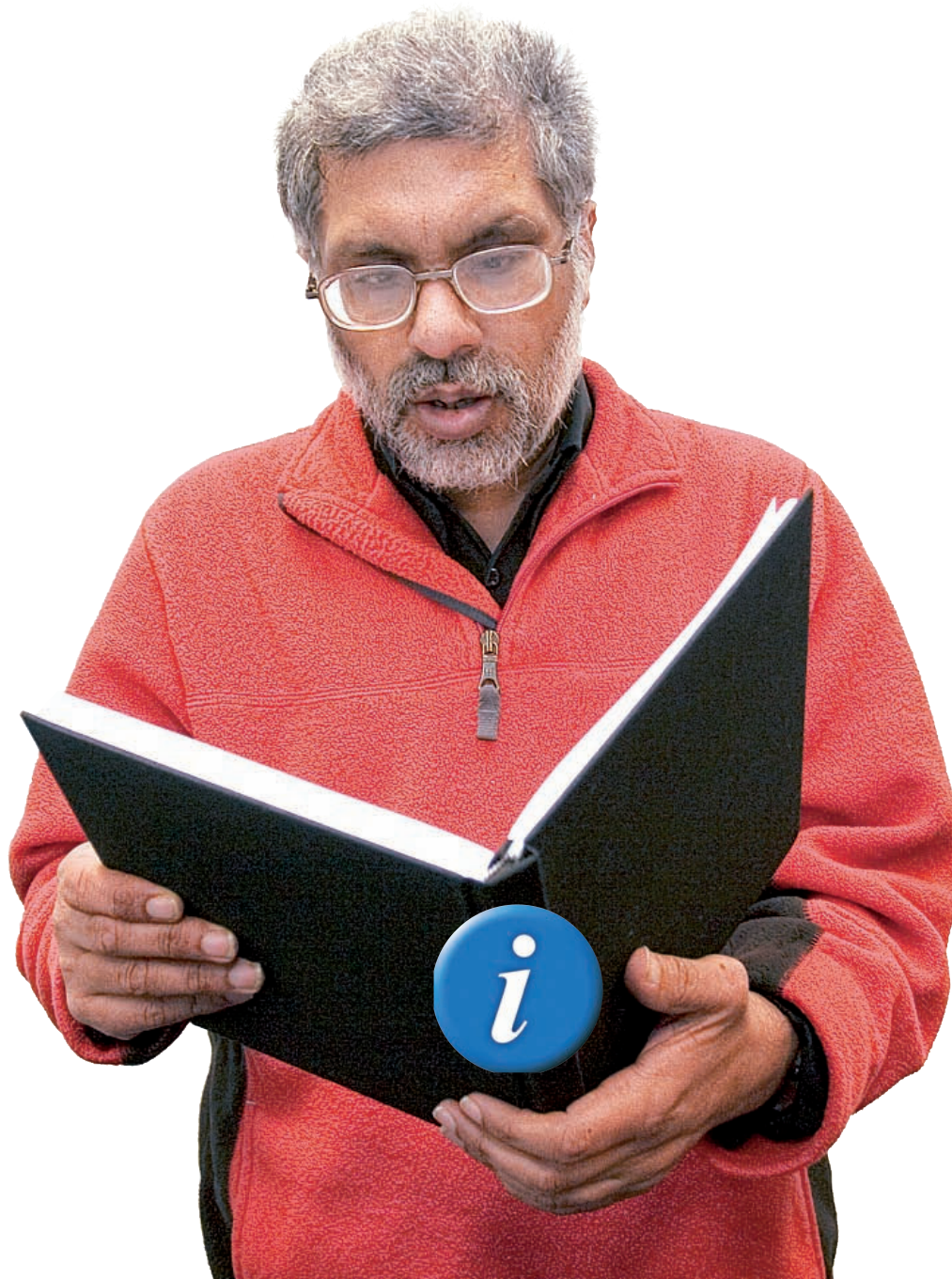
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Learning Disability Services New Service Model

Shepway Day Services Consultation
November 2011



Consultation for changes to Shepway Day Services



1. Why are we consulting?

In 2001, the Government produced a White Paper called 'Valuing People'. Its aim was to improve the lives of people with a learning disability.

In January 2009 "Valuing People Now" was produced. This was a review of the original strategy. It acknowledged the progress that had been achieved but it also stated that what is needed through this new strategy is the transformation of the lives of people with learning disabilities and family carers.



It asked for stronger leadership from local authorities and set out four top priorities:

- Personalisation
- Health
- Daytime/employment
- Housing.

In 2010 Kent County Council (KCC) launched 'Bold Steps for Kent', medium term plan to 2014/15. This sets out Kent's aims to evolve into commissioners of community care services rather than as providers of them. KCC is keen to see the development of sustainable community resources in partnership with the private, voluntary sector and social enterprise. The proposed new service model will assist in fulfilling this desired outcome.

As part of Kent's response to 'Valuing People Now' we set up The Good Day Programme so that we could co-ordinate changes in the way day services are delivered to people with learning disabilities and enable people to lead a more full and meaningful life.



The site where the Shepway Resource Centre is currently based has hosted learning disability day services since 1985.

We know that some people have been going to these services for a long time and many feel comfortable and happy with it.

The Shepway Resource Centre no longer meets the current and future requirements for people with learning disabilities. So we propose that Shepway Day Service move off the site altogether and transfer with the existing staff team to community locations instead.

For some time now the Shepway Day Services has been working hard with service users to help them become more involved in the community and to offer people the chance to get involved in a wider range of community based activities.

We are starting a consultation programme and want to know what you think of this proposal.

We would like to hear from:

- everybody who uses any of the existing services
- parents and carers
- people who might want to use any of the services in the future
- other service colleagues, health, education and housing
- staff and union representatives
- the general public.

2. Why does the Shepway Day Services need to change?



- Since 'Valuing People' and 'Valuing People Now', the staff and service users have been using and getting to know a variety of community groups and activities. This has meant that more and more activities have been taking place in different community locations and people have had a chance to take part in a wider range of things
- A lot of younger people leaving school and their parents want something different and are put off by the style and position of the building. They are choosing other independent day services and supported employment.



This has meant that there are now fewer new people wanting the Shepway Resource Centre as their chosen day service. As a result, the number of people using the Shepway Resource Centre has fallen and the building is now too big and empty

- The service relies upon mini buses to get to and from the building, and this makes accessing community activities more difficult. Also it can mean that some people are on the vehicles for over 2 ½ hours a day whilst they travel across the district picking up and dropping off individuals. More suitable transport arrangements are needed for the future to access local services
- In offering a wider choice of community activities a close working relationship has developed between the SRC and The Bridge Centre and over recent months both services have merged with staff coming together to provide one seamless service.
- The design of the building is old fashioned and despite money being spent on it over the years, there are still lots of things that need updating and replacing. Given that we want more community based activities and greater flexibility, we do not think that we should spend large amounts of money on the building, as it is no longer what is needed.



3. What will the new service look like?

Outlined below is the proposed new service model. Below this is a summary explaining each element.

Offer people a range of facilities, activities and opportunities in their local community within inclusive settings.

This will be achieved by:

- increasing opportunities to make Direct Payments more available to enable people to design and purchase a personalised service
- identifying through Person Centred Planning any elements of the current service provided by Shepway Resource Centre and The Bridge Centre that has the potential to become a Social Enterprise
- investing in community hubs in order to stimulate the external market to deliver opportunities within the local community
- providing skilled staff to support people to access services within the local community
- negotiating with residential care providers to deliver or purchase a day service as described in the agreed support plan
- moving away from large congregate and segregate building based services.



Increasing opportunities to make Direct Payments more available to enable people to design and purchase a personalised service.

People currently attending the Shepway Resource Centre and the Bridge Centre will receive a day care review. They will be consulted for their views which will identify, what and how new day services are to be delivered. These services could be purchased from existing and new service providers through personal budgets and individual contracts. Work will need to be undertaken with commissioners and contracting colleagues to commission what people want.

Identifying through Person Centred Planning any elements of the current service provided by both Shepway Resource Centre and The Bridge Centre that has the potential to become a social enterprise.



From the outcomes of Person Centred Planning where it has been identified that people want to retain elements of the current service, these will be considered for their potential in becoming a social enterprise. Those assessed to be feasible for social enterprise specifications will be drawn up and the appropriate service provider appointed through competitive tender.

Supported employment will be key in ensuring that, where appropriate, people have support to move into paid employment both within social enterprises and in the mainstream business market. This is essential to ensure a purpose for individuals, therefore offering greater choice and fulfilment. Additional investment in supported employment to accomplish this will be taken into account through the remodelling of the existing in house learning disability staff group.

Investing in community hubs in order to stimulate the external market to deliver opportunities within the local community.



A number of 'community hub' type facilities will be available close to where people live offering shared space for people with a learning disability and a place to meet up and take part in inclusive activities. Funding will be provided to enhance or provide accessible space, equipment and facilities within these community buildings to meet people's needs, including: sensory and therapeutic equipment and adult changing facilities. With these improved modern facilities in place there will no longer be a need for the existing out dated large segregated building currently occupied by Shepway Resource Centre.

Funding has recently been provided in The Bridge Centre in Hythe to enhance accessible facilities.

A Shepway Community Hub Focus Group has been established to research the local area and identify suitable community hub options.

The proposed community hub locations identified by the focus group are:

- Folkestone Sports Centre
- The Bridge Centre
- The Community Network
- The Marsh Academy Community Centre

Providing skilled staff to support people to access services within the local community.



Suitably skilled staff to support people to access services within their local community will be provided through the remodelling of the existing in house learning disability day services staff group. This remodelled staff group will be restructured to reflect the changes required to deliver community based support in place of building based support. The proposed process of identifying and tendering for potential social enterprises and independent sector day care will result in some appropriately skilled staff transferring to an alternative service provider. The remaining staff group roles will be remodelled to provide a community based support type function. Once this is complete the new model of a community support service will be put forward to the external provider market through a second phase of competitive tender.

Negotiating with residential care providers to deliver/ provide or purchase a day service as described in the agreed support plan.

There are a relatively high percentage of people currently accessing Shepway Resource Centre and the Bridge Centre who live in residential care, 30%. Negotiations will take place with individual people and their residential care providers to identify where it is more beneficial for the person to have their residential care provider deliver or purchase day care opportunities as an alternative choice to Shepway Resource Centre and The Bridge Centre.



Moving away from large congregate and segregate building based services.

A number of 'community hub' type facilities will be available close to where people live offering shared space for people with a learning disability and a place to meet up and take part in inclusive activities. Capital funding will be provided to enhance/provide accessible shared space.

This will provide equipment and facilities to meet people's needs, including: sensory and therapeutic equipment and adult changing facilities. With these improved modern facilities in place there will no longer be a need for the existing out dated large segregated building currently occupied by Shepway Resource Centre.

Some of the community based services will include:

- colleges and adult education
- Community Network
- community resource centres
- Folkestone Sports Centre
- local community groups
- private and voluntary service providers
- social enterprise opportunities
- sport and leisure centres
- supported employment
- The Bridge Centre
- The Marsh Academy Community Centre.

We recognise the importance to people of maintaining and developing existing and new friendships. Particular attention will be given to ensure people continue to meet their friends and have opportunities to make new friends.

What it might look like for John:



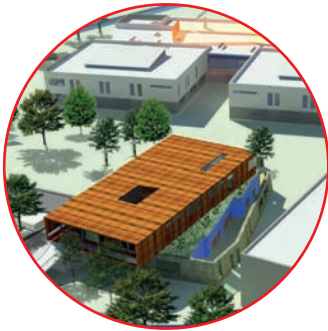
The Bridge Centre



Folkestone Sports Centre



Community Network



The Marsh Academy Community Centre



Meeting with friends



Personal Interests



Private and voluntary service providers



Work opportunities



4. What happens next?

We have planned that this consultation will take 14 weeks, as we want to make sure that as many people as possible are included.

There will be a range of ways for people to get involved and tell us what they think, including:

- individual meetings
- information road shows
- a questionnaire that will be available online and at these meetings

This means that your views will be gathered by 28 February 2012 and we will bring all these different responses together in a report that we will be published in April 2012.

5. Questions and answers

Here are some questions we thought you might ask:



Will I still get the same level of service?

- Yes.
The changes will affect where activities take place and if anything open up more opportunities- we do not aim to reduce the service people receive, instead we aim to make it much more person centred.



Where will the new service be?

- We know where people live and using this information we will look at places that are central, accessible and affordable
- There will also be a central office base.



How will this new service be better?

- Planning the service around your views will ensure that what is provided is wanted and working with you and local community groups will make the service more inclusive
- A new community based service will be more flexible and person centred, as it will make accessing wider opportunities easier and open up more choices.



What will this mean for the staff?

- The service will continue to be provided by the existing staff team, ensuring a good level of service
- The whole team will have access to an office and management support and will continue to have access to a full training programme.



How will the new service promote safety?

- For some time now we have been accessing a variety of community facilities and so have worked in partnership to put successful systems in place, raise awareness and encourage good practice
- Contract and monitoring performance
- Care Management reviews
- Safeguarding vulnerable adults policy and procedures.



How will transport needs be met?

- It is our aim to develop a service that is more accessible and personalised. Your Care Manager will discuss any needs on an individual basis.
- Through Care Management review.



Are these changes being made to save money?

- No
We aim to use the current budget differently, which means that the budget will be used to support people more flexibly instead of spending it on buildings. If any efficiency is achieved through the new service model then this will save money.



If you have further questions or comments there will be opportunities to share these in the following ways:

- consultation meetings and events
- completing the questionnaire
- logging on to the website www.kent.gov.uk/learningdisability
- emailing: GoodDayProgramme@kent.gov.uk



This questionnaire is available in alternative formats and can be provided in a range of languages.

Please contact us on 08458 247 100

Shepway Day Services

Consultation Questionnaire

We want to know what is important to you when planning for the future, this questionnaire is just one way you can get involved.



Please complete questions which are relevant to you



1. Please tell us what you like and don't like about the service provided at Shepway Resource Centre?

Like	Don't like

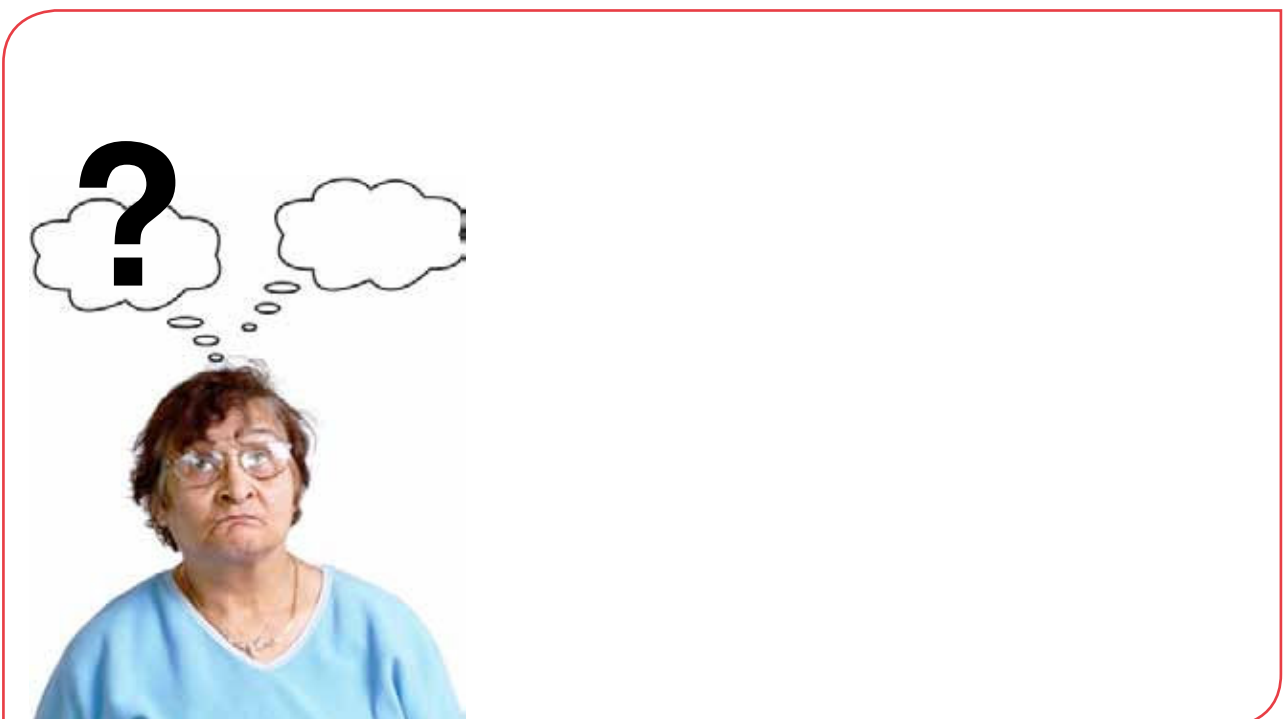
2. Please tell us what you like and don't like about the services provided in the community?

Like	Don't like

3. Please tell us how you think the proposals for a community based service may affect you?



4. What worries you about the changes?







5. What could be done to make you feel better about the changes?




6. Please tick the boxes you are most interested in?



Activity/service		Already do	Would like to do
	Computing		
	Cookery		
	Reading and writing		
	Exercise and sport		
	Music		
	Gardening/conservation		
	Art and craft		
	Drama		
	Health and wellbeing		
	District Partnership Group		
	Pottery		
	Travel training		
	Meeting friends		
	Access to library, museum and interesting places		
	Speaking up groups, student committee		

Activity/Service	Already do	Would like to do
 Help to get a qualification		
 Advice on local resources e.g. benefits, job opportunities, education, housing		
 Work experience placements		
 Horseriding		
 Sensory and therapeutic sessions		
 Cycling		
 Daily living skills		
 Rambling		

6. Please tell us if there is anything else you would like to do or you feel is important?





8. Work

The new modernised service could assist people in getting ready for work. Please tick the boxes that apply to you.



	Yes	No
Would you like to work		
Would you like to do voluntary work		
Would you be interested in hearing more about supported employment and work.		

9. Direct Payments

Direct Payments help you to control your own life, so you can have more choice - just like everyone else.

A Direct Payment is money that Adult Social Care can give you to buy your own support and services.

Direct Payments	Yes	No
I already have a Direct Payment		
I would be interested in hearing more about Direct Payments		



It would be useful if you would please let us know (by putting a tick in the box) if you are a:



Person with a disability



Parent/carer



Social services employee



Health services employee



Other

Please specify

.....

.....

.....

If you would like us to respond to any questions or comments you have made in the questionnaire could you please provide your contact details below:



Name:

.....



Address:

.....

.....



Telephone :



Email:

Thank you for taking the time to complete this questionnaire.



February

Please return the completed questionnaire by
28th February 2012 to:



Kim Duff
Kent County Council
2nd Floor
Brenchley House
123/135 Week Street
Maidstone
Kent
ME14 1RF

**This questionnaire is available in alternative formats and can
be provided in a range of languages.**

Please contact us on 08458 247 100



By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
 Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **LOCAL ACCOUNT 2012**

Classification: Unrestricted

Summary: The Cabinet Member for Adult Social Care and Public Health agreed that Policy Overview & Scrutiny Committee should be briefed on the timetable for the Local Account 2012 development.

FOR DECISION

The Local Account was published for the first time in December 2011.

Introduction

1. (1) The coalition Government has taken a different view to performance management within Councils, reducing the nationally led assessment process and scored judgements, and focussing instead on local performance frameworks which are transparent, evidence better outcomes for people and allow local people to hold their Council to account.

(2) There have been indications that sector and peer led reviews and assessments are likely to be a new way of assessment for Councils, although this thinking has not formally translated into guidance or policy as yet.

(3) In October 2010, “Transparency in outcomes: a framework for quality in adult social care” was published. This document developed the ideas that were published within:

- A vision for adult social care: Capable communities and active citizens
- Think local, act personal: A sector-wide commitment to moving forward with personalisation and community-based support.

(4) The government has consulted on the quality framework, and a response to the consultation was issued on 31 March 2011. The revised framework includes the development of quality standards for social care, a set of performance measures that are to be used for national benchmarking, as well as the introduction of peer reviews, and an annual statement on outcomes and priorities called a **Local Account**.

Policy Context

2. (1) ‘Active Lives’ sets out a common understanding of our key objectives amongst public, staff, partners and providers, supporting strong partnership working. Our services support the delivery of Kent’s medium term plan Bold Steps particularly the key themes of putting the citizen in control and tackling disadvantage.

Content of the Local Account.

3. (1) Transparency, as relates to Local Accounts, has been identified as one of the most important objectives for transforming social care in terms of publishing information, developing relationships between commissioners and providers and enabling people to hold their Council to account. The Government's response to "Transparency in outcomes" stated that it was important because of the way it will be *"Opening up information on adult social care, and fostering a new conversation between service providers, commissioners, and those they serve will together enable a new relationship where accountability is held locally, and citizens feel empowered to challenge – or to commend – local services."*

(2) Local Accounts are proposed to replace the report previously published by the Care Quality Commission.

(3) As the Local Account will allow Councils to self assess and demonstrate its own progress against its own priorities, it is thought that it will contribute to the work that Local Government group is developing around sector-led assessment. This new model expects councils to be held to account the public and publish priorities and progress.

(4) The response to the "Transparency in outcomes" consultation does not set out what a Local Account should look like, on the basis that this will curtail local preferences and response to their own public. Instead, suggestions, including comments from other Councils have concluded that the Local Account could:

- Be adapted locally, and be aligned with other partners: Engagement with citizens could be jointly through the Health and Well being boards.
- Be developed with the involvement of service users and carers
- Be signed off by the local Health watch.
- Include some nationally set data or service information so that comparisons can be made, as well as local data and information.
- Include the views and impact of providers

(5) The consultation response concludes that Councils should test the format and content of a Local Account in 2011-12.

(6) Further guidance sent to Directors of Adult Social Services in July 2011 by the "Promoting Excellence in Councils Adult Social Care Programme Board" recommending that Councils should consider producing a short Local Account during 2011/12, as a way of demonstrating and describing its performance to Local people.

(7) The Board has recommended that:

(a) although the Account is locally determined, it should be person focussed, and aimed at the whole community. User engagement, either through user feedback, or actual engagement in the development of the account should be considered.

(b) In addition, *"Councils also need to consider how they will secure appropriate independent and professional challenge and scrutiny of the quality of the outcomes achieved, for example, via external review of safeguarding practice, user feedback, overview and scrutiny, LINKs/Healthwatch, use of complaints, case file audits and monitoring of external services."*

(c) The Local Account should be produced in 2011/12 and cover the 2010/11 period as a minimum, but ideally a time period more recently. The Account should be published on the Council website, and possibly by the lead Cabinet Member.

(d) The Board recommends that the Local Account should report on the quality of adult social care in the area but it could be useful for Councils to be thinking through the following issues:

- How is the local account citizen/consumer driven?
- How might external challenge of the local account be undertaken in a way which allows an objective perspective?
- How does the local account relate to reporting on health outcomes?
- How does the local account fit with corporate reporting?
- What is the role of the LSP and other Boards, including the Adult Safeguarding Board, in feeding into the local account?
- What will be the role of the Health and Well-being Board (HWB Board) in feeding into the local account? “

Timetable for the future

4. (1) The process this year has been to create a document to be published by the timescale required (attached as appendix 1). Next year, we would like to approach the document differently and consider the following:

- Align the process to the Business Planning timeline
- Incorporate user and carers views
- Create a user and carer working group
- Member involvement

(2) The following timetable has been drafted to incorporate the above:

	Timescale
Agree framework, template and events for engagement with stakeholders: LiNKS Carer groups User groups Voluntary Sector Health	February – April 2012
Consultation with groups	May 2012 – June 2012
First Draft completed	June 2012
Editorial Board – users and carers	July 2012
Final Draft completed	August 2012
Scrutiny of account through: ASCPHPOSC (Policy Overview & Scrutiny Committee) Health Watch Health and Wellbeing Board	September 2012
Publish Account	October 2012

Recommendations

5. Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to NOTE the recommendations for the 2012 version listed in section 4.

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Background Information:
FSC DMT report – dated 21 September 2011

Local Account 2011

Families and Social Care – Adults





Kent County Council
Families and Social Care - Adults
Brenchley House
123/135 Week Street
Maidstone
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ME14 1RF

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Foreword

Welcome to Kent County Council's Local Account for 2011

Active Lives is our ten year vision of how people who use our services and carers, would like to see adult social care in 2016. Active Lives Now sets out how we will turn that vision into a reality in the next three years.

The last two years have been a time of significant change with major national and local initiatives which are changing the whole of adult social care. We have transformed our services to embrace the wider national agenda of personalisation as described in 'Putting People First'.

The future of adult social care is still at the centre of much national debate as we explore how to meet future demand through a system that is fair and affordable. Kent continues to influence this debate, sharing good practice and successful outcomes from new ways of working together with partners, service users and carers.

The public, particularly service users and their carers, are at the centre of everything we do. We are creating a culture that will give people greater choice and control in their lives and have put into place services to support people.

We have made good progress in:

- **Personalisation:** Transforming social care in Kent by giving people choice and control over their own services
- **Safeguarding:** Continuing to work with partners to keep people safe
- **Carers:** Continuing to support carers through our partnerships with carer's organisations and direct services to the people carers support
- **Accessible Services:** Joined up working with partners using community hubs and Gateways and improving information, advice and guidance to make it easier for people to get the services they need
- **Employability:** Promoting employability and ensuring the skill needs of people with mental health problems or learning disabilities are met
- **Prevention:** Helping people to stay in their own homes for longer through the enablement service and use of assistive technology such as TeleHealth and Telecare
- **Involving service users and carers:** Working with service users and carers in service design, particularly engaging with hard to reach groups and people from black and minority ethnic communities
- **Contribution to reducing health inequalities:** Working with partners to improve the general health of the people of Kent, particularly those groups of people who are most likely to have poorer health.

As everyone knows this is a challenging time for all of us, having to balance the increasing numbers of people who need care and support with the impact of the recession on public finances. This document shows how we intend to tackle these changes. This includes:

- developing local initiatives to enable people to live safe and fulfilled lives in their own communities
- promoting a personalised service that offers choice and flexibility to meet people's individual needs
- working with the public and partners to develop a wide range of preventative services which help people to tackle problems at an early stage
- focusing on innovation and technology to develop new services eg; developing further the Kent Card, Telehealth and Telecare and the use of broadband
- working with partners to develop efficient seamless services which are easily accessible
- continuing to evaluate and develop the way services are delivered
- partnership working with Health on joint commissioning and integrated services.

This Local Account has described how we have managed our care and support services for adult social care service users in Kent in 2011. We could not have made progress without the contribution of a wide range of people including service users and their carers. We hope people will continue to work with us in shaping the future of adult social care in Kent.



Graham Gibbens

Cabinet Member for Adult Social Care and Public Health



1.0 Introduction

1.1 What this document is about

The coalition Government has taken a different view on assessing Council's which focuses on local performance frameworks which are transparent, evidence better outcomes for people and allow local people to hold their Council to account. This statement outlines our priorities and outcomes; it is called a Local Account.

There have been many changes in social care, both nationally and locally. Adult Social Care will be facing a challenging time in the next few years brought about by:

- increasing demand as a result of better health care and advances in medicine which mean people, including those with complex health conditions, live longer
- the impact on public spending caused by the recession
- increased public expectation that services should meet needs based upon the individual, giving them choice and control
- fewer young people entering the social care workforce and the ageing of the current workforce
- The implementation of Self-Directed Support, based on a number of initiatives and policies launched by the Government setting out a national vision for social care in the future focusing on independence, personalisation and partnership working.

1.2 Bold Steps for Kent

In January 2010, ahead of the General Election, Kent published Bold Steps for Radical Reform, a blueprint for the future of local government and local public service delivery. Recognising the need for the future government in Westminster to deliver unprecedented savings, Kent concluded that some £15-21 billion of savings could be achieved through radical devolution of public services to the local level, so they can be reshaped around local need. This in turn reduces the national deficit through the abolition of unnecessary regional bureaucracy and quangos. Under the new coalition Government, the centralised and bureaucratic Government machine is being rapidly dismantled. We now have the opportunity, and the responsibility, to deliver the new vision for public services as set out in 'Bold Steps for Radical Reform'. Bold Steps for Kent is therefore our new medium term plan to 2014/15, and it sets out how we will deliver this radical reform.

The three aims of Bold Steps for Kent are:

- To help the Kent economy to grow
- To put the citizen in control
- To tackle disadvantage.

1.3 Role of Adult Social Care

Adult Social Care is influenced and led by a number of strategic documents. These are:

Active Lives Now, a strategy which sets out the next three years (2010 – 2013) for Kent Adult Social Care.

Adult Social Care is about to embark on significant change in structures and budgets. This is because over the next four years, funding for public services will fall significantly as the Government seeks to tackle the massive hole in the UK's public finances. We expect to have to make budget savings of between 25-40% over the next four years.

Kent Adult Social Services became the Families and Social Care Directorate from 1st April 2011, and Active Lives now will continue to be implemented; the County Council will be working to deliver '**Bold Steps for Kent**'.

'Active Lives' sets out a common understanding of our key objectives amongst the public, staff, partners and providers, supporting strong partnership working.

Our services support the delivery of Kent's medium term plan 'Bold Steps', particularly the key themes of putting the citizen in control and tackling disadvantage.

The overall purpose of our services is:

To help the people of Kent to live independent and fulfilled lives safely in their local communities.

The core business objectives are:

- Personalisation and increase in the number of people using direct payments
- Development of community based preventative services
- Continued reduction in the rate of adults being placed in residential and nursing care

1.4 Safeguarding

We remain committed to ensuring that people in situations which could put them at risk of abuse and danger, receive the support they need to maintain their personal safety and independence.

Safeguarding is a major priority for us. Through Multi-Agency Public Protection Arrangements and the Multi-Agency Safeguarding Vulnerable Adults Executive Board, we have in place robust adult protection processes which safeguard vulnerable adults effectively.

Kent County Council takes a personalised approach to safeguarding. Raising awareness amongst members of the community about safeguarding is key. Safeguarding Awareness Week is held annually in June. The County Council and partner agencies promote safeguarding awareness in community areas, including libraries and shopping centres.

In addition, we learn from compliments and complaints, analysing those we receive and ensuring that the lessons learnt are used to improve service delivery across the county.

Surveys are an essential component of evidencing that people are asked about what outcomes they want from safeguarding and whether those outcomes have been achieved. The results of surveys are analysed and reported to senior management and Directors. In addition, we have recently implemented a feedback tool to obtain feedback from people who have been the subject of safeguarding alerts. This ensures that victims of abuse are more directly engaged in the safeguarding process and to inform and improve practice.

In Kent, adult safeguarding is subject to independent scrutiny and checking. The Families and Social Care (FSC) Directorate Management Team and the Cabinet Member for Adult Social Care and Public Health receive quarterly safeguarding performance reports. The report has been developed using an improved framework for quality assurance as agreed with the Cabinet Member and Directors in FSC. Strong governance arrangements are in place, with reporting lines from the Corporate Management Team and the Cabinet Member for Adult Social Care and Public Health through to Locality Teams.

Lessons learnt from internal and external audits are used to inform and improve practice and also feed into the Families and Social Care Strategic Adult Safeguarding action plan. For example, following an external audit of FSC adult safeguarding files in January 2011, it was identified that there was a need for risk assessments to be improved. A rolling programme of risk training was implemented and future audits demonstrated improved practice.

An important aspect of the quality assurance framework has been the review of the safeguarding processes. One of the key recommendations of the practice audits was to review the safeguarding investigation process. This was undertaken using the nationally recognised LEAN methodology. This methodology focuses on processes with a view to 'drive out the waste'.

Kent County Council's Kent Care Services On-line Directory gives members of the public the opportunity to provide feedback the quality and safety of local services. The website also identifies where there are safeguarding, contract compliance and poor practice concerns with establishments. Links are available for people to access other websites for information, including the Care Quality Commission website. Information about whistleblowing and the complaints process are also available on-line and in hard copy.



2.0 Priorities and Challenges

2.1 Population

Kent has a population of around 1.4 million which is set to grow by 10 per cent by 2021 and Kent Families and Social Care (FSC) has supported over 45,000 people above the age of 18 in the last year.

Demographic pressures will also have an impact on the workforce as there will be a decline in the proportion of people of working age. Indeed a large proportion of the FSC workforce are over the age of 40 and as demand for services increases there will be a major challenge to ensure there is a workforce to meet this need. It is important that we manage these competing challenges over the years ahead.

The demographic changes described here give some insight into the challenges which are facing social care over the next 10 to 20 years and of course these are not exclusive to Kent.

The number of people over 85 in the UK, the age group most likely to need care, is expected to increase by over 50 per cent to 1.9 million over the next decade. There are around 246,994 people over the age of 65 living in Kent (taken from Mid Year Population Forecasts 2008) and it is estimated that the total number of over 65's will grow by 39.3 per cent by 2021 and that the total population of over 85's will rise by 100 per cent by 2026¹.

Another consideration is the increase of sensory disability in older people as the number of sight impaired people alone is expected to double over the next 20 years. Based on 2006 Mid Year Population estimates there are 118,047 people between the ages of 61 to 80 with some degree of deafness in Kent, compared to 53,486 between the ages of 16 to 60. A significant increase will put great pressure on resources.

Key Facts

During 2010-11, **47,045** referrals for adult social care were received by Kent County Council. This is a weekly average of 905 clients requesting assistance from Kent County Council. **15,038** of the 47,045 referrals were resolved immediately at the point of contact with advice, information or small pieces of equipment.

Kent County Council Adult Social Care had the 2nd highest number of referrals during 2010-11 within our comparator group with only Essex County Council receiving more with 50,495 referrals within the year.

2.2 Financial Climate

The impact of the recession will play its part in putting a further strain on social care funding. The total outstanding Government net debt in the UK was £848.5 billion in January 2010, which is equivalent to 59.9 per cent of Gross Domestic Product. This accompanied by demographic pressures will inevitably impact upon resources available to the social care system.

2.3 People Living with Dementia

Dementia presents a significant challenge to social care and health; there are currently 700,000 people in the UK with dementia, of whom approximately 570,000 live in England. Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

By 2023 the number of people living with dementia will have increased dramatically. In West Kent we estimate there are around 7,716 people with late onset dementia, while by 2023 this will have increased by 50 per cent. There is a similar pattern in East Kent, where there are around 8,706 people with late onset dementia and by 2023 this will have increased by 43 per cent².

Key Facts

During 2010-11, 1,920 of service users were in receipt of a specialist dementia service in either residential and/ or nursing home care or in receipt of community based services.

In 2010-11, Kent had a higher than average number of service users with dementia, and had the 5th highest number of service users with dementia within our comparator group following West Sussex with 2,340, Essex with 2,330, Gloucestershire with 2,270 and Leeds with 2,080.

2.4 People who are Carers

There are 127,848 known carers in Kent. Of these carers in Kent, 78 per cent or almost 100,000 are of working age. Some will have given up work to care but the majority will be somehow combining caring with paid work. According to the 2001 Census there are 2,564 men and 1,394 women working full time whilst caring for more than 50 hours per week. 90,572 carers are providing care for one to 19 hours per week. In Kent the average numbers of carers per district is 12.4 per cent, higher than the national average of 10 per cent and as people live longer with more chronic health conditions such as dementia the number of carers will rise further.

The combination of an ageing population and a decline in the working age population means that the role carers play in the workforce will be of increasing importance; with carers combining caring with paid work.

A Carers UK study showed that nearly 21 per cent of carers who provide more than 50 hours of care a week report that they are not in good health, compared with only 11 per cent of the non carer population. 25,203 of Kent's carers provide more than 50 hours of care per week. 51.3 per cent of these carers care for a spouse or partner. People who provide long hours of care are twice as likely to be in poor health themselves and need to be supported both in their own right and in their role as a carer. As people care for partners in the later stages of their lives they too will perhaps be suffering from some ill health and frailty.

¹ Source: South East Plan Strategy-based (Nov 08): Population Forecasts by ten year age group and gender

2.5 People with Learning disabilities

As described in the Government paper, 'Valuing People Now', Emerson and Hatton have estimated that the total number of adults with a learning disability (aged 20 or over) will increase nationally by 8 per cent to 868,000 in 2011 and by 14 per cent to 908,000 by 2021. Significantly all the growth projections show much higher increases in the number of adults aged over 60.

As people live longer and expectations rise, there will be a further strain on resources to support people with a learning disability. It is also worth highlighting that there is a significant number of people with a leaning disability who are placed in Kent from other local authorities and this puts further pressure upon Adult Social Care.

57 per cent of the learning disability residential places were occupied by individuals placed by other authorities.

Key Facts

During 2010-11, 66.4% of Learning Disabled Adults were in settled accommodation at the time of their latest assessment or review (National Indicator 145).

The average for comparable Local Authorities for 2010-11 was 56.4% of Learning Disabled Adults were in settled accommodation at the time of their latest assessment or review.

Key Facts

During 2010-11, 5.9% of Learning Disabled Adults were in employment at the time of their latest assessment or review (National Indicator 146).

The average for comparable Local Authorities for 2010-11 was 6.5% of Learning Disabled Adults were in employment.

2.6 People with Physical disability

Greater technology and knowledge of long term conditions have enabled people to manage complex conditions while preventative interventions have helped to either prevent or delay onset. Whilst medical advances and more efficient support mechanisms are something to be celebrated, the implication is that greater demand will lead to future pressure on resources.

18 per cent of Kent's population have some limiting long term illness or disability and the prevalence of a number of long term conditions is set to rise. East Kent has the largest proportion of people living with a long term condition or disability, with Thanet having the largest proportion.

Healthy living programmes and other such preventative measures will go some way to reducing diseases and conditions which can physically disable. They will also help to reduce longer term effects of unhealthy lifestyle choices such as obesity.

2.7 People living with Mental health conditions

Our newly launched '*Live it Well*' a strategy sets out how we aim to improve improving the mental health and well-being of people in Kent and Medway. Mental health problems are estimated to be the most common cause of premature death and years of life lost with a disability. The average life expectancy of most people with schizophrenia is 10 to 12 years less than those without, due to increased physical health problems and a higher suicide rate. However, the prevalence and impact of mental health problems on society is poorly appreciated.

Key Facts

During 2010-11, 68.4% of Adults in contact with secondary mental health services were in settled accommodation at the time of their latest assessment or review (National Indicator 149).

The average for comparable Local Authorities was 67.8% of Adults in contact with secondary mental health services were in settled accommodation at the time of their latest assessment or review.

The wider cost of mental health problems to the country (estimated at £77 billion in 2005/06) exceeds Treasury spending on the NHS as a whole at £76 billion.

The Mental Health Joint Strategic Needs Assessment for Kent and Medway estimates that:

- At any one time there are at least 163,000 people with common mental health problem(s), of whom 25 per cent need treatment
- More than 60,000 people have severe mental illness and around 12,000 people are estimated to have severe and enduring mental illness.

As the population in Kent increases, more and more strain will be put on the mental health support systems including carers.

Key Facts

During 2010-11 8.2% of Adults in contact with secondary mental health services were in employment at the time of their latest assessment or review. (National Indicator 150)

The average for comparable Local Authorities was 10% of Adults in contact with secondary mental health services were in employment at the time of their latest assessment or review.

² Kent Adults Carer's Annual report 2008 - 2009

2.8 Information, advice and guidance when you most need it

People often come to us at a time of crisis or great change in their lives and it is at this first contact that information is crucial. It is at this moment information can be most powerful in enabling the individual to make choices about their support and take control of their situation. For some, advice and guidance is all that is needed and that will be the end of our involvement, but, better information, advice and guidance for people using adult social services, or indeed those paying for their own services, is a vital part of our vision.

The Kent Contact and Assessment Service enables people to have easier access to services, information, advice and guidance. We have worked with members of the public to establish an information, advice and guidance policy and work continues around this.

The development of Gateways across the county is now into the second phase. These are customer focused and bring a range of services and information under one roof and into local communities, such as shopping centres. Gateways can be found in most large towns in Kent.

Our online directory of care services (www.kent.gov.uk/careservices) provides information about adult social care services in Kent, including bed vacancies in residential homes. The website has links to other useful sources of information for people using adult social care services. A hard copy directory is also produced annually. The online self-assessment service enables people to assess their support needs at a time that suits them and find out what support they may be eligible for.

2.9 Summary of the Challenges facing Kent

- Reduced Budget
- Increasing number of people who need support
- Supporting people with more complex needs lasting for a longer time.



3.0 What we have been doing

Each of the Bold Steps headings are supported by a number of key functions that are essential to the running of the service in delivering our overarching theme. These are broken down into three headings. They are:

- Personalisation
- Voluntary Sector
- Joint and Partnership Working

3.1 Personalisation

3.1.1 About Personalisation

Personalisation is about putting individuals firmly in the driving seat of building a system of care and support that is designed with their full involvement and tailored to meet their own unique needs.

Individuals receive their own budget and can decide how, who with and where they wish to spend that budget in order to meet their needs and achieve their desired outcomes.

Whilst there is a focus on social care and support services, the principles of personalisation are being embedded into a range of other public service areas such as health and education.

Truly personalised services and support mechanisms must be co-produced with staff, people who use our services, their family members, carers and the wider general public. Examples of this are:

- the Adult Active Lives Now strategy
- the Good Day Programme
- the Information, Advice and Guidance policy
- involvement in interview panels for staff recruitment
- the formation of combined service user and staff groups which have been used to inform the Self Directed Support project
- Kent Local Disability Partnership Board
- LINKs.

3.1.2 What this means for our service users and carers?

- People having more control over their care and support
- People knowing the level of their allocated Personal Budget
- People being able to use direct payments if it suits them
- People being supported to have choice in how they are supported
- People having access to good information, advice and guidance

3.1.3 Personal Budgets and the Kent Card – How they are used

Over a thousand people use the Kent Card. This offers a secure and convenient way for an individual to pay for their own support. It can be used in the same way as a VISA debit card, which does not require a bank account.

Key Facts

As at 30th September 2011, 36.7% of Kent Families and Social Care service users were in receipt of a Personal Budget and/ or a direct payment to help deliver their care. This gives service users increased choice and control in how their care will be delivered. (National indicator 130).

The average for comparable Local Authorities for 2010-11 was 30.5% of all social care service users being in receipt of a Personal Budget and/ or direct payment to help deliver their care.

3.1.4 Prevention

Ensuring we can offer people choice and control over their care and support packages has also led to the development of a range of initiatives with Health and other partners to meet the needs of individuals. These include:

- a range of services which are geared towards preventing people going into hospital if they do not need to, or having to stay in longer than necessary because there is no support at home. These services are also having a significant impact in reducing the rates of delayed hospital discharges across Kent
- Enablement services - where Enablement is offered, trained Enablement Support Workers will work with the individual (in the individual's home) to help them learn (or re-learn) important skills that are needed for everyday life – such as improving an individual's confidence getting in and out of their bath or preparing their own meals; or improving their mobility so they can walk to the shops or to visit friends/neighbours.

Enablement is not about doing things for the individual, it is about giving them the skills and confidence to complete daily living tasks themselves. The Enablement worker may also identify pieces of equipment and minor adaptations that could assist the individual to live independently.

Each individual's Enablement programme is tailored to their individual needs. At the start of Enablement, the individual and Enablement Supervisor agree some realistic goals to achieve during the service. These goals are focussed on the individual's eligible needs and will attempt to remove or reduce the individual's eligible needs by the end of the period of Enablement. Enablement Support Workers work with the individual to achieve their chosen goals. The Enablement Supervisor and Support Workers regularly review progress and are required to keep the KCC assessor up to date with progress.

- The Kent Contact and Assessment Service now offers direct access to equipment and minor adaptations across the whole of Kent so that people can obtain small pieces of equipment, such as grab rails, quickly to enable them to live safely and independently at home.

Key Facts

As at 30th September almost 500 people per month were receiving an Enablement service. Of these, over 65% of people returned home with their independence and either no care package or support through equipment.

3.1.5 Tele -Technology

People want to stay in their own homes for as long as possible. Managing long term conditions by using preventative technology and making adaptations to people's homes are some ways in which independence at home can be achieved. This can also prevent admissions to hospital whilst giving the individual peace of mind and a sense of control over their condition.

It is just as important to have a home that is suitable, of good quality and designed to meet the needs of an individual. That is why we have developed a number of housing schemes catering for people with a whole range of needs from older people to people with learning disabilities through Private Finance Initiatives (PFI) in partnership with district councils.

Based on this success we have developed in partnership with five district councils, another PFI bid to deliver 228 units of social housing for vulnerable people.

We are using technology such as TeleHealth and Telecare to support people with long term conditions to maintain their independence and give them reassurance. Kent is also now part of a Government Whole System Demonstrator pilot which has enabled us to offer the benefits of TeleHealth and Telecare to over 2,000 people. People are able to monitor long term conditions at home providing them with reassurance and the ability to remain independent in their own homes with the use of alarm and monitoring systems.

The initial finding of the Whole System Demonstrator Programme showed that if delivered properly, telehealth can substantially reduce mortality. This is supported by evidence of a reduced need for admissions to hospital, a lower number of days spent in hospital and an overall reduction in the time spent in Accident and Emergency Departments.

Across Kent there are a range of initiatives that are being developed with Health and other partners. These include the Enablement service and the Urgent Care Demonstrator and other projects to support those people in the community who have falls, dementia or have had strokes.

Kent County Council have developed, a Public Health Strategy which looks at how KCC can work with partners to reduce health inequalities across the county. In Kent Adult Social Services we are supporting the stopping smoking initiatives and focusing on improved, quality mental health services.

Key Facts

As at 30th September 2011, 963 people were benefiting from the use of telecare technology.

3.1.6 Support to participate in community life

We have been putting new initiatives in place to encourage the development of stronger, safer, sustainable communities to support vulnerable people locally.

The introduction of the personalisation agenda allows greater freedom in how people meet their own needs and in doing so gives the opportunity for creative thinking around social and community engagement and local services.

3.2 Voluntary Sector

We work with the voluntary sector across the services to enable more people to receive support. The voluntary sector deliver key services across Kent.

Families and Social Care values the continuing work of our voluntary sector partners that support vulnerable people to remain independent in their own homes for as long as possible. Our level investment which is just over £15m per year goes to a range of voluntary sector organisations who provide services such as day care, carers, short breaks, information and advice, volunteer and a broad range of early intervention and preventative services. In addition, significant funds are awarded to the voluntary sector organisations with charitable status through a contract.

Key Facts

In 2010-11, over 10,500 people were receiving support from the voluntary sector at any one time.

3.3 Joint and Partnership Working

Families and Social Care values the continuing work of our voluntary sector partners that support vulnerable people to remain independent in their own homes for as long as possible. Our level investment which is just over £15m per year goes to a range of voluntary sector organisations who provide services such as day care, carers, short breaks, information and advice, volunteering and a broad range of early intervention and preventative services. In addition, significant funds are awarded to the voluntary sector organisations with charitable status through a contract.

3.3.1 Integrated Services

As services become more integrated and better partnership working takes place, sharing information between health, district councils and the voluntary sector will need to underpin commissioning plans. Alongside this we need to explore how service users access services to make sure their experience is improved and that we are delivering cost effective services.

With our partners we need to ensure we have more efficient joint working arrangements through single assessment and commissioning of services with systems which allow us to move further and faster in improving public access. The aim will be to streamline assessments whilst ensuring people still have the ability to self-assess. Integrated assessment could then lead to an integrated system of paying benefits through Individual Budgets to service users and carers through the mechanism of a combined card. This would help relieve confusion, saving time and giving more control to the service user.

We will take every opportunity to explore new ways to work with health, particularly in community settings. This will include improving end of life care, supporting people with long term conditions and their carers and promoting health and healthy lifestyles.

An example of improved joint working with the NHS is the piloting of Eye Clinic Liaisons who will provide patients with timely information, signposting and emotional support at point of diagnosis. This will include maximising the use of the Kent Card and Personal Health Budgets to give people greater choice and control in choosing their services.

A National UK Visions Strategy is to be developed locally by health and social care.

We will also be working with health partners to promote access to health and social care services for gypsy and traveller communities and to tackle the health inequalities experienced by this community.

The Gateway programme in Kent is transforming access to public services for Kent residents.

It is a partnership across local government (county, district and borough councils), fire, police, NHS, the voluntary sector and central Government, providing joined up access to services with a focus on customer service. Discussions have taken place with the Eastern and Coastal Kent Primary Care Trust and the Dover Gateway is shortly opening a clinical room for Health. There are now plans and funding available to introduce a clinical room at Gateways in Thanet and to design them into Herne Bay, Sheppey, Ashford and Shepway in due course.

Key Facts

In 2011, an average of 450 people per month were referred to intermediate care services to enable them to be discharged from hospital and be able to return home.

As at 30th September, 87% of older people (aged 65 and over) who received an intermediate care service were still at home three months later, with either a reduced care package or no care package at all (National Indicator 125).

The average for comparable Local Authorities for 2010-11 was 81.8% of service users receiving a rehabilitation or intermediate care service achieved independence.

3.3.2 Carers

Caring touches all our lives and at some point most of us will either give or receive care and support. Many people do not see themselves as carers: they are mums or dads, husbands, wives, partners, brothers, sisters, friends and neighbours. Carers are not a separate or distinct group. People from all walks of life, ages, ethnicities and backgrounds are carers.

Adult Social Care's approach towards carers along with their partners in health, voluntary and third sector services is based on the understanding that carers are the main providers of community care and support and they should be supported in their role. Much of our work with carers is delivered through numerous partnerships and some through grants, service agreements and contracts with the voluntary and independent sector.

Adult Social Care's role is to ensure that carers are supported and have access to timely information, support to care which can include short breaks, practical assistance, and emotional support and help to maintain their own health. We have a role in ensuring their voices are heard and that they are treated as partners in care.

Together with the PCTs, the Council has developed a 5 year strategy for mental health in Kent. It is designed to improve mental health and wellbeing and is called "Live it Well". With Sevenoaks MIND as a partner, the "Live it Well" website has been created to make this strategy public. It gives easy access to good quality information and to local resources that can improve everyone's mental health and wellbeing. The website is at www.liveitwell.org.uk

Additionally, the Council and the PCTs fund the Mental Health Matters helpline in Kent. The Mental Health Matters Helpline (0800 107 0160) is available out of hours on weekdays and 24 hours during weekends and holidays. A mental health carers support group is funded in each locality in Kent.

This service will shortly be expanded to include out of hours support to Carers too.

We provide a range of short breaks which benefit carers and the people they support. More flexible respite opportunities have been shaped around individual need.

Key Facts

During 2010-11, 38.3% carers needs were assessed or reviewed by Kent County Council (National Indicator 135).

The average for comparable Local Authorities for 2010-11 was 29.6%.

3.3.3 Transition from Childhood to Adulthood

In order to enable disabled children to meet their full potential in adulthood there needs to be a seamless transition of support services as people move into adulthood which is focused on the individuals needs. We now have transition co-ordination workers who work with young people and their families, schools and education to help smooth the process from moving into adulthood.

3.3.4 Non-Residential Charging Policy

In order to continue to provide support to the widest number of people in Kent who are eligible for social care support and to enable FSC to continue to invest in preventative services. FSC revised its non-residential charging policy which came into effect in December 2011.





4.0 How you help us shape our services

4.1 Public Involvement

Involving the public in our service design and listening to the feedback people have given us has always been a priority, and we have continued to act upon this. However, in April 2009 the Duty to Involve was introduced. The aspiration of the duty was to:

“embed a culture of engagement and empowerment. This means that authorities consider, as a matter of course, the possibilities for provision of information to, consultation with and involvement of representatives of local persons across all authority functions”.

The Local Government and Public involvement in Health Act 2007 section 138 (taken from Creating Strong Prosperous Communities Statutory Guidance July 2008).

This duty has raised the profile of involving the public so it is no longer a choice but an obligation. Following an inspection by the Care Quality Commission in 2009, the action plan highlighted that a key focus for the future needs to be involving more disadvantaged groups.

We will continue to work with a broad range of partners and groups who are seldom heard to ensure we involve everyone and that their needs are addressed. These will include Learning Disability Partnership Boards, those with complex needs and black and minority ethnic groups.

We are currently working with the public to develop a partnership model. The purpose of this is to give the public, particularly those who use our services, a greater influence over the decisions made by the Directorate's Strategic Management Team.

We will involve service users and their families in designing services, ensuring we have engaged with disadvantaged or vulnerable groups. We will continue to be held to account by service users, carers and their families, and ensure we keep them informed about how we are doing and give them every opportunity to help us review and evaluate services and outcomes.

4.2 Service Improvement – Complaints

Performance Measure	Actual Fin Yr 2009/10	Estimate Fin Yr 2010/11	Target or Forecast Fin Yr 2011/12
Number of Complaints	436	527	547
Number of Compliments	502	598	560

5.0 Looking to the coming year

We have identified a number of priorities that will guide us through the next three years as we continue to modernise social care in Kent. The Adults Transformation programme will be how our service will contribute to the delivery of Bold Steps in Kent. These priorities have come from:

- feedback from service users and carers
- surveys and research with the public
- customer feedback
- government frameworks and policy
- understanding the make-up of the people we support and other relevant analyses of need and demography
- our own performance monitoring and management - understanding what we are doing well and areas that need more focus.

This is our timetable for the creation of next year's Local Account (2012).

	Timescale
Agree framework, template and events for engagement with stakeholders: LiNKS Carer groups Service user groups Voluntary Sector Health	February – April 2012
Consultation with groups	May 2012 – June 2012
First Draft completed	June 2012
Editorial Board – service users and carers	July 2012
Final Draft completed	August 2012
Scrutiny of account through: Adult Social Care and Public Health Policy and Overview Scrutiny Committee Health Watch Health and Wellbeing Board	September 2012
Publish Account	October 2012

Glossary of key words:

Assessment

The overall process for identifying and recording the health and social care risks and needs of an individual and evaluating their impact on daily living and quality of life, so that appropriate action can be planned. An assessment can be completed in a number of ways including over the telephone, online and face-to-face.

Co-Location

The practice of different parties/organisations sharing a residence.

Dementia

The term 'dementia' is used to describe the symptoms which occur when the brain is affected by specific diseases and conditions. These include Alzheimer's disease and sometimes can be the result of a stroke. Dementia is progressive, which means the symptoms will gradually get worse. How quickly dementia progresses will depend on the individual. Each person is unique and will experience dementia in their own way.

Direct Payment

A Direct Payment is one way in which a Personal Budget can be received. It is a form of payment which enables the individual to receive their Personal Budget into a bank account so they can manage their own money as well as purchase and manage their agreed support.

Enablement

Enablement services are free to anyone who is eligible for a service after a needs assessment; there is no financial assessment. This is an intensive, short term service of three to six weeks designed to maintain independent living skills.

Gateways

Gateways offer a convenient public service access point in a retail-based location using the latest innovative technologies and strong partnership working. The Gateway model has engaged partners in its development and roll out, including central and local Government, NHS, Police, Fire, Job Centre Plus and so on.

Good Day Programme

The programme is "about ensuring better days" for people with learning disabilities through the exercise of personal choice and control over their activities, with support if necessary to enable them to lead a full and meaningful life.

Joint Strategic Needs Assessment

Joint Strategic Needs Assessment describes a process that identifies current and future health and well-being needs in light of existing services. It informs future service planning and identifies "the big picture" in terms of the health and well-being needs and inequalities of a local population.

Kent Card

The Kent Card is a secure and convenient way of receiving a Direct Payment for community support and assistance. It is an easy way for an individual to pay for their support. It is a Chip and PIN VISA card which does not need a bank account. People can use it to pay for their support in the same way as using a VISA debit card.

Learning disability

Learning disability is not mental illness or dyslexia. People with a learning disability find it harder than others to learn, understand and communicate.

Mental health

Mental health is about how we think, feel and behave. One in four people in the UK have a mental health problem at some point in their lives, which affects their daily life, relationships or physical health.

Personalisation

The process by which state provided services can be adapted to suit the individual. In social care this means everyone having choice and control over the shape of their support along with a greater emphasis on prevention and early intervention.

Personal Assistant

This is someone who can help an individual to live independently at home. They may take them shopping or help them to cook or clean but they are employed by the individual, rather than by the local authority or a care agency and therefore the individual has legal responsibilities as their employer.

Personal Budget

A Personal Budget is the amount of money allocated to a person as a result of a social services assessment. The allocation of this money will be transparent. A social services Personal Budget could be part of an Individual Budget in the future. Individual Budgets bring together the money allocated to a person from a variety of sources, for example Supporting People.

Personal Health Budget

This is similar to a social services Personal Budget and is being piloted until 2012. A Personal Health Budget makes it clear to the individual and the people who support them how much money is available for their NHS care so they can discuss and agree the best way to spend it. It is likely to be used for therapies, personal care, lifestyle advice and self-management courses. It will not be able to pay for emergency care and care you normally get from a family doctor.

Private sector

Organisations which are run for private profit and are not controlled by the state.

TeleHealth

Clients using TeleHealth use equipment to take their vital sign measurements in their home environment.

Telecare

Telecare uses sensors, such as movement or fall detectors, linked to a response centre to safeguard the client's well-being. Both Telecare and TeleHealth technologies help frail, elderly and people with long term conditions to live at home independently.

Voluntary and community organisations

These are self-governing organisations, some being registered charities, some incorporated non-profit organisations and some outside both these classifications which rely heavily on volunteers and are independent from formal structures of government and the profit sector/ private sector.



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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **ADULT SOCIAL CARE BUDGET FORECAST AND SAVINGS REPORT 2011/12**

Classification: Unrestricted

Summary: A report on the updated quarter 2 forecast outturn against the budget for Kent Adult Social Care to include savings as at November 2011.

Introduction

1. (1) This is the third report for 2011-12 to this Committee on the forecast outturn against budget for Adult Social Care and includes an update on savings.

Background

2. (1) Policy Overview and Scrutiny Committees consider the draft Medium Term Financial Plan at their November and January meetings. To enable a more informed discussion, three reports will be presented to the Committee on a regular basis:

a) **Budget Monitoring reports**

A detailed quarterly budget monitoring report is presented to Cabinet, usually in September, December and March, and a draft final outturn report in June. A report for each directorate is annexed to the summary report, and the annex for the Adult Social Care Directorate will be presented to this Committee at the meetings following those Cabinet meetings. This will help inform this Policy Overview and Scrutiny Committee about current trends, pressures and management actions in advance of the next year's budget setting

b) **Performance data**

This will be reported at least half-yearly to this Committee.

c) **Outturn report**

Effectively an amalgam of the above two, the outturn report will summarise both the financial and performance information for the whole of the preceding year.

(2) Informed by these reports, the Policy Overview and Scrutiny Committees will be in a stronger position to question and comment on the future budget and medium term proposals, as they will be asked to do at the November and January meetings.

Second Quarter Updated Monitoring report

3. (1) The revenue monitoring exception report for Adult Social Care was presented to Cabinet in December; this indicated an overall revenue under spend of £2.537m, which is a decrease in under spend of £0.044m to the forecast submitted in the second quarter's full monitoring report.

(2) The £2.537m under spend breaks down as follows:

- £3.522m Older People
- £0.119m Learning Disability
- +£1.801m Physical Disability
- £1.209m All Adults Assessment & Related
- +£0.467m Mental Health
- +£0.045m Management & Support

-£2.537m Total

(3) The forecast under spend on this portfolio has marginally reduced by £0.044m this month from £2.581m to £2.537m. Although only a small movement overall, there are some larger compensating movements within this. The movements over £0.1m this month are:

-£0.106m Strategic Management & Directorate Support – a reduction in the pressure from £0.151m to £0.045m, the majority of this is due to savings within the efficiency team, which is currently operating with a smaller structure than was budgeted for, together with smaller movements on safeguarding adults and strategic commissioning.

-£0.309m Learning Disability Direct Payments – an increase in the underspend from £0.224m to £0.533m mainly against the gross budget, as a result of a lower take up from that assumed in the budget.

+£0.318m Older People Direct Payments – a reduction in the under spend from £0.548m to £0.230m as a result of both an increase of 28 clients in the month, coupled with the expected continued growth to year end.

-£0.186m Physical Disability Direct Payments – a reduction in the pressure from £0.359m to £0.173m mainly against the gross budget, as a result of a lower take up than previously assumed.

-£0.166m Learning Disability Domiciliary Care – an increase in the underspend from £1.099m to £1.265m largely reflecting the restatement of the forecast based on the trend of payments to external providers.

+£0.158m Older People Nursing Care – a reduction in the underspend from £0.242m to £0.084m due to a decrease in the forecast income expected as a result of restating the forecast using the year to date up until the end of October and assuming that a similar pattern continues for the remainder of the year, based on the latest 3 months trend of client billing runs

-£0.176m Physical Disability Residential Care – a reduction in the pressure from £1.334m to £1.158m. This is mainly against the gross budget (-£0.151m) due to a net decrease of 5 clients, together with a slight over recovery of income against the Preserved Rights service.

+£0.508m Learning Disability Supported Accommodation – a reduction in the underspend from £0.599m to £0.091m. This is mainly due to:

- +£0.320m as a result of a specific bad debt provision, reflecting the directorate's prudence with regards to three S256 clients where three other local authorities are currently refusing to settle raised invoices;
- +£0.214m pressure as a result of net changes to 9 clients;
- £0.080m reduction in the block beds contract.

-£0.172m Assessment of Vulnerable Adults & Older People – an increase in the underspend from £0.865m to £1.037m. The main client groups contributing to this overall movement are Mental Health -£0.108m and Learning Disability -£0.061m. The Mental Health movement is primarily in relation to the deletion of the director and associated posts and formation of the MH Professional Assurance Team – Social Care. The Learning Disability movement is as a result of staff leaving and vacancy management.

Directorate Management & Support (ASC) -£106k – There is a reduction in the forecast of £106k, the majority of this is due to savings within the efficiency team, which is currently operating with a smaller structure than was budgeted for, with smaller movements on Safeguarding adults and strategic commissioning.

(4) This position assumes that all but £1.946m savings identified within the Medium Term Plan will be achieved.

	£'m
LD/PD Procurement	1.403
Slippage of Enhanced Domiciliary	0.100
Slippage of Jointly Owned Properties	0.040
Non residential charging	
Delay in implementing -NDI/DREA	0.403
Total	1.946

The achievement of savings are pivotal to the delivery of an efficiently managed budget. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged.

Our monitoring process includes ensuring all high cost placements and support packages are reviewed, plus a continued analysis and scrutiny of all requests for waiving of third party top ups to the cost of placements, and rigorous on-going panel arrangements.

(5) The capital monitoring position against the revised budget of £6.853m, is a variance of £0.333m. The revised budget reflects the previously reported re-phasing of £5.334m in relation to both the Older Persons Strategy & IT related projects.

The further variance of £0.333m reflects the request to re-phase the following budgets:

	£'m
Swift Enhancements	-0.272
Other minor projects	-0.061
Total Re-phase	-0.333

The Swift enhancement project request to re-phase is mainly as a result of a delay in the acquisition of several enhancements whilst requirements are reviewed.

Recommendations

4. (1) Members of the Adults Social Care and Public Health Policy Overview and Scrutiny Committee are asked to NOTE the latest monitoring position for revenue, capital and savings.

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Background documents: None

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **SEPTEMBER 2011 UPDATE FOR PERFORMANCE FOR ADULT SOCIAL CARE, AND MONITORING OF THE PROJECTS, DEVELOPMENTS AND KEY DECISIONS IDENTIFIED IN THE 2011/12 ANNUAL OPERATING BUSINESS PLANS FOR FAMILIES AND SOCIAL CARE, ADULT SERVICES**

Classification: Unrestricted

Summary: This report provides Members with the Core Monitoring performance report for the second quarter, based on September 2011 and provides an update on the key projects and key decisions identified in the 2011/12 annual operating business plan.

Introduction

1. (1) The Adult Social Care Directorate has a statutory duty to provide performance information to the Department of Health on an annual basis, via a number of statutory returns.

(2) The process for assessing Adult Social Care in Councils is changing. In the past, Councils were expected to complete the Self-Assessment Statement which provided information about all aspects of our approach to strategic management, policy, service management, planning and customer care across all client groups. Regular meetings with our Care Quality Commission (CQC) colleagues were also in place to provide the opportunity for discussion about the issues the Directorate faced, together with our plans to maintain or improve performance. This was used by CQC, together with the performance indicators, to form an assessment of each Council.

(3) The role that CQC now has in relation to assessing Councils is much reduced; there is no longer a requirement for self assessment nationally, and no process for judging each Council.

(4) In its place, there are proposals and ongoing work to determine how Councils can rely on peer and sector led assessment, as well as having mechanisms in place for the public to hold Adult Social Care to account. Clarity and guidance are still to be issued.

(5) Although performance indicators are still being collected for the immediate future, the Department of Health has started a “Zero Based Review” of all data collections for Adult Social Care, with the long term intention that Councils will only submit information that is relevant and meaningful, and will provide a reduced burden in producing statistics. This new streamlined approach fits with the personalisation of social care more appropriately than the old framework and is welcomed by Kent.

(6) Within Kent a new Core Monitoring report is produced on a quarterly basis. This is the second quarter’s report, which updates Members on progress against our key performance areas, as identified within Bold Steps.

Key points

2. (1) The results for the ongoing performance indicators for Adult Social Care can be found at **Appendix A**.

(2) The Directorate has seen some good improvements. In particular, the Directorate has delivered:

- An increase in the number of people who have been offered a personal budget. At the time of this report, nearly 9,000 people were in receipt of a personal budget. Of these, over 2,500 people were in receipt of an ongoing direct payment.
- Over 970 people are in receipt of telecare to help maintain their independence. The end of year position is likely to be over 1000.
- The number of people who are offered enablement continues to increase, although the quarterly target is not yet being met. Other forms of support, such as provision of equipment, may be enabling people instead of the formal enablement service, and this is being carefully monitored.
- People continue to be assessed in a timely way. The assessment process includes the provision of enablement. Assessments should not be lengthy, nor should they be cut too short. This indicator shows that 78% of assessments are being completed within six weeks.

Half Year Monitoring of the Projects, Developments and Key Decisions identified in the 2011/12 Annual Operating Business Plans for FSC, Adults Services

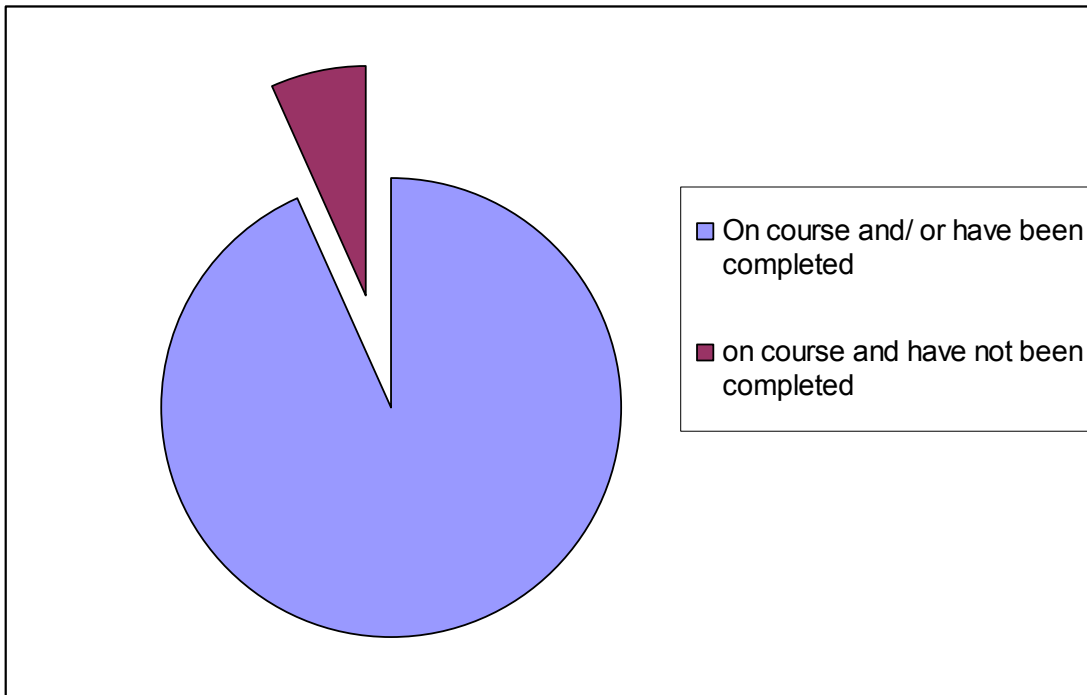
3. (1) This section covers Adult Social Care Services projects, developments and key decision items in the Annual Operating Plan for the Directorate.

(2) The business plans monitoring is based on ‘exception reporting’. This means the reporting only contains narrative information on those activities listed in the business plans that are “not on course” and have yet to be completed.

(3) Explanation for the reasons why certain projects were not progressed as planned are provided for those areas that are deemed “not on course” according to standard assessment criteria.

(4) Across the Annual Operating Plans, 106 Projects, Developments and Key Decision were included, of which:

99 are on course and/ or have been completed, leaving 7 that are “not on course” and thus have not been completed. Details of these can be found in **Appendix B**.



(5) Comments or queries can be directed to Elouisa Matthews or Michael Thomas-Sam

Recommendations

4. (1) Members are asked to NOTE the half year performance update and the update for Half Year Monitoring of the Projects, Developments and Key Decisions.

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Background documents: None

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KCC Quarterly Performance Report

Quarter 2, 2011/12

PAT Version: 15 November 2011



Foreword

Welcome to Kent County Council's Quarterly Performance Report for Quarter two of financial year 2011/12. This is a new report which replaces our previous quarterly Core Monitoring report.

Within this report you will find information on our Key Performance Indicators (KPIs) and a range of other essential management information. This report should be read in conjunction with our financial monitoring report which includes information on service demand levels and related key activity indicators.

The council is committed to deliver its strategic objectives as outlined in our medium term plan **Bold Steps for Kent** and the suite of underlying strategies underpinning our Framework for Regeneration, 'Unlocking Kent's Potential'. This report will continue to be developed over the coming year to provide more information on our progress against the key priorities within Bold Steps. The report will also continue to provide essential information on the delivery of Core Services for our local residents.

At the heart of Bold Steps for Kent are our three ambitions:

- To Help the Economy Grow
- To Tackle Disadvantage
- To Put the Citizen In Control

We are working in very challenging times, with significantly less funding from central government and increased demand for services. The need for a new approach to public services has never been more urgent given the pressures on public finance and how the people of Kent want their services to be delivered. KCC must radically rethink its approach to the design and delivery of services whilst ensuring Kent remains one of the most attractive places to live and work. Our Bold Step priorities will help us achieve this.

We will seek to improve this report each quarter and in future reports new information will be included. We hope you find this report useful and we would welcome any feedback on how we can improve it.

Paul Carter
Leader of the council
Kent County Council

Katherine Kerswell
Managing Director
Kent County Council

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Data quality note

All data included in this report for current financial year are provisional unaudited data and are categorised as management information. All results may be subject to later change.

Bold Steps for Kent

The Kent County Council medium term plan for 2011 to 2014, **Bold Steps for Kent** was published in December 2010. A follow on document, providing clearer focus on the top priorities and the measures of success and key milestones, **Delivering Bold Steps**, was published in July 2011. Our future performance reports will begin to provide information on our progress in delivering these top priorities.

Our key priorities within Bold Steps are as follows:

1. Improving how we procure and commission services
2. Supporting the transformation of health and social care in Kent
3. Ensuring all pupils meet their full potential
4. Shaping education and skills provision around the needs of the Kent economy
5. Delivering the Kent Environment Strategy
6. Promoting Kent and enhancing its cultural and sporting offer for residents
7. Building a strong relationship with key business sectors across Kent
8. Working with our partners to respond to the key regeneration challenges in Kent
9. Supporting new housing growth that is sustainable and with the appropriate infrastructure
10. Delivering 'Growth with Gridlock'
11. Improving access to public services and moving towards a single initial assessment process.
12. Empowering social services users through increased use of personal budgets
13. Establishing a Big Society Fund to support new social enterprise in Kent
14. Ensuring we provide the most robust and effective public protection arrangements (safeguarding vulnerable children and adults)
15. Improving services for the most vulnerable people in Kent
16. Supporting families with complex needs and increasing the use of community budgets.

Many of these priorities will be delivered in partnership with other public agencies in Kent and all of these priorities build on and support our Framework for Regeneration, Unlocking Kent's Potential.

Key to RAG (Red/Amber/Green) ratings applied to KPIs

GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
↑	Performance has improved relative to targets set
↓	Performance has worsened relative to targets set

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.

Performance Assurance Team (PAT)

Against each KPI there is a section to provide information on any discussion by the Performance Assurance Team (PAT). PAT's role is to consider and challenge the action plans for improving performance, including addressing constraints and barriers and to provide additional reassurances to elected members that the action plans and the information being reported within this report are robust.

PAT meets monthly and is chaired by the Deputy Managing Director. Membership includes a nominated director from each directorate. It also includes two non-executive directors (NEDs) who are staff from the grass roots of the organisation. This ensures PAT has cross-organisation membership from all levels to provide a 'whole organisation' approach to improvement.

PAT meetings include discussion with accountable managers of poor or declining performance on KPIs included in the Quarterly Performance Report. Any red or repeatedly amber indicators will be called in by PAT for further discussion. As well as looking at performance problems PAT will also examine areas of strong performance, the 'greens', and whether this could be as a result of good practice or learning that can be shared or any 'gold plating' that may need to be addressed.

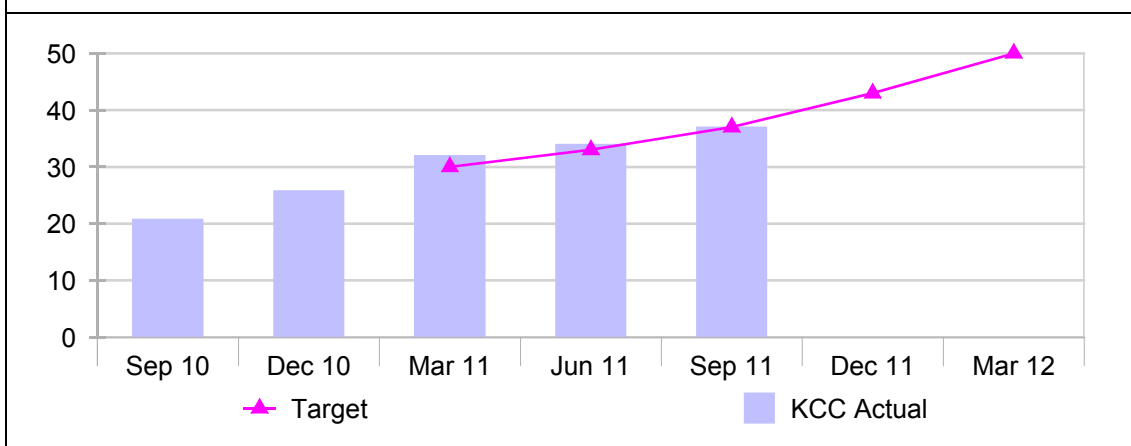
Prior to each PAT meeting the Cabinet Member for Business Strategy, Performance and Health Reform receives a full set of papers and the Chair of PAT will brief him on the key issues. They meet again following PAT to discuss the outcomes and agreed actions which are also summarised in a formal report. The Cabinet Member for Business Strategy, Performance and Health Reform has the right to attend PAT during the year and the Chair of Governance and Audit Committee may also attend PAT on an exceptional basis.

Summary of Performance for our KPIs

Indicator Description	Service Area	Page	Current Status	Previous Status	Direction of Travel
Percentage of adult social care clients who receive a personal budget and/or a direct payment	Adult Social Care	7	Green	Green	↑
Number of adult social care clients receiving a telecare service	Adult Social Care	9	Green	Green	↑
Number of adult social care clients provided with an enablement service	Adult Social Care	11	Amber	Amber	↑
Percentage of adult social care assessments completed within six weeks	Adult Social Care	13	Green	Green	↑
Percentage of clients satisfied that desired outcomes have been achieved at their first review	Adult Social Care	15	Green	Green	↑

Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment **Green ↑**

Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	Bold Steps Ambition	Put the Citizen in Control
Cabinet Member	Graham Gibbens	Director	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	Division	Older People and Physical Disability



Data Notes.
Tolerance: Higher values are better.
Unit of measure: Percentage
Data Source: Adult Social Care Swift client system

Data is reported as the snapshot position of current clients at the quarter end.

NB This is different from the national indicator which is measured for all clients with a service during the year, including carers.

Trend Data	Previous Year			Current Year			
	Sept 10	Dec 10	Mar 11	Jun 11	Sep 11	Dec 11	Mar 12
KCC Result	20.8%	25.8%	32.0%	34.0%	37.0%		
Target			30%	33%	37%	43%	50%
Client numbers	4,220	6,430	7,740	8,085	8,892		
Rag Rating			Green	Green	Green		

Commentary

Performance continues to improve and is currently on target and the forecast is that the target of 50% should be achieved by March 2012.

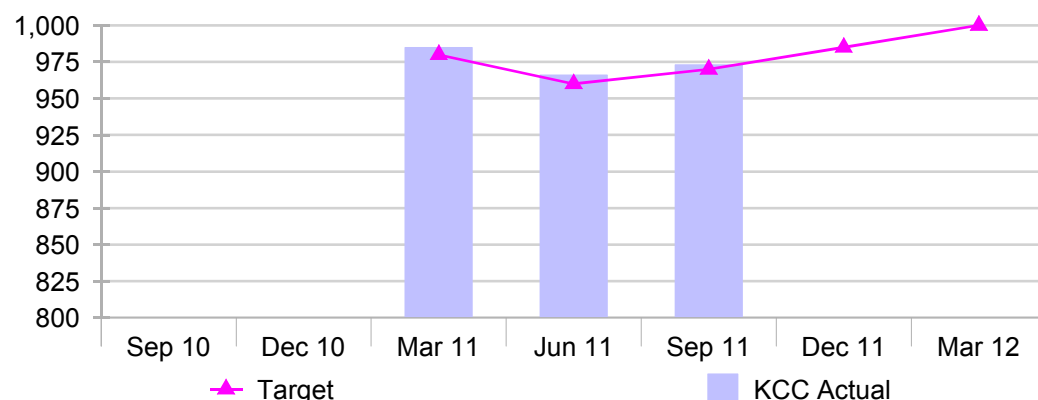
This key indicator is monitored on a monthly basis by the Directorate Management Team and the indicator receives a high level attention nationally as well as locally. For the related national indicator Kent achieved 20.5% in 2010/11, compared to a national rate of 28.9%.

<p>Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment</p>	<p>Green ↑</p>
<p>What actions are we taking to improve performance (and drivers of performance)</p>	
<p>The approach to increasing Personal budgets is threefold:</p> <ol style="list-style-type: none"> 1. To ensure that all new clients are allocated a personal budget. 2. To ensure that all existing clients are allocated a personal budget at review. 3. To ensure that data quality issues are resolved as and when they arise. <p>Targets have been set across all the teams, and management information reports have been developed to allow the teams to manage and monitor their own performance. This is monitored and managed closely by the Divisional and Directorate Management Teams through Locality Action plans. These Action plans ensure that performance is owned by the operational teams, accountability is held at all levels, including setting individual targets and action plans, and training and knowledge gaps are identified, whether policy, practice or system based. Training has already been provided for localities where it has been highlighted and this will continue. Teams are targeted if data quality or practice issues arise:- e.g where reviews have been undertaken and no personal budget is allocated. The Locality Coordination Management meeting set up a Task and Finish group to achieve underlying organisational changes in order to get permanent improvement, with one head of service as the owner, reporting to Divisional Management Team.</p>	
<p>Risks and mitigating actions</p>	
<ol style="list-style-type: none"> 1. Performance timelines not being met, due to aligned work not being managed such as: number of reviews to increase as planned. 2. Organisational and cultural changes taking longer than planned. 3. Productivity targets new for the service and may take longer than planned to develop. <p>Action taken</p> <ol style="list-style-type: none"> 1. Tight system of performance monitoring in place; performance identified as key priority and escalation routes clarified. 2. Individual responsibilities, team and managers' responsibilities clearly set out ; implementation monitored and addressed at supervision and action planning reviews. 3. Timelines clearly set out. Additional expertise and knowledge on implementing productivity monitoring being sought. 	
<p>Discussion and actions agreed by PAT</p>	
<p> </p>	

Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment	Green ↑
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Number of adult social care clients receiving a telecare service	Green ↑
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Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	Bold Steps Ambition	Put the Citizen in Control
Cabinet Member	Graham Gibbens	Director	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	Division	Older People and Physical Disability



Data Notes.
Tolerance: Higher values are better.
Unit of measure: Number
Data Source: Adult Social Care Swift client system

Data is reported as the position at the end of the quarter.

No comparative data from other local authorities is currently available for this indicator.

Trend Data – at quarter end	Previous Year			Current Year			
	Sept 10	Dec 10	Mar 11	Jun 11	Sep 11	Dec 11	Mar 12
KCC Result			985	966	973		
Target			980	960	970	985	1,000
Rag Rating			Green	Green	Green		

Commentary

Numbers are increased in the quarter and continue to be ahead of target.

The decrease in the actual and target numbers between March 2011 and June 2011 was primarily due to a review of all clients and a data quality update that was undertaken in preparation for mainstreaming the service within the operational teams. Some service

Number of adult social care clients receiving a telecare service**Green ↑**

users opted to finish their involvement when the Whole System Demonstrator finished in April. The data quality clean up was completed in June and the baseline starting point was re-set to 960.

The target for the end of this year remains at 1,000, in line with the targets set within the teams' action plans.

What actions are we taking to improve performance (and drivers of performance)

Telecare has very recently been transferred to the operational teams as a mainstream service and is being promoted as a key mechanism for supporting people to live independently at home through the teams. This includes promoting telecare through the hospitals and also to support people after a period of enablement.

The availability of new monitoring devices (for dementia for instance) is expected to increase the usage and benefits of Telecare, and a strategy and commissioning plan are being developed in relation to this.

In addition, the provision of Telecare can now be included within Personal Budgets, where appropriate.

Targets have been set across all the teams, and this is monitored and managed closely by the Divisional and Directorate Management Teams through Locality Action plans, which requires Heads of Services to report back on their performance, ensure targets are set at team and individual level and identify training needs within their teams.

Risks and mitigating actions

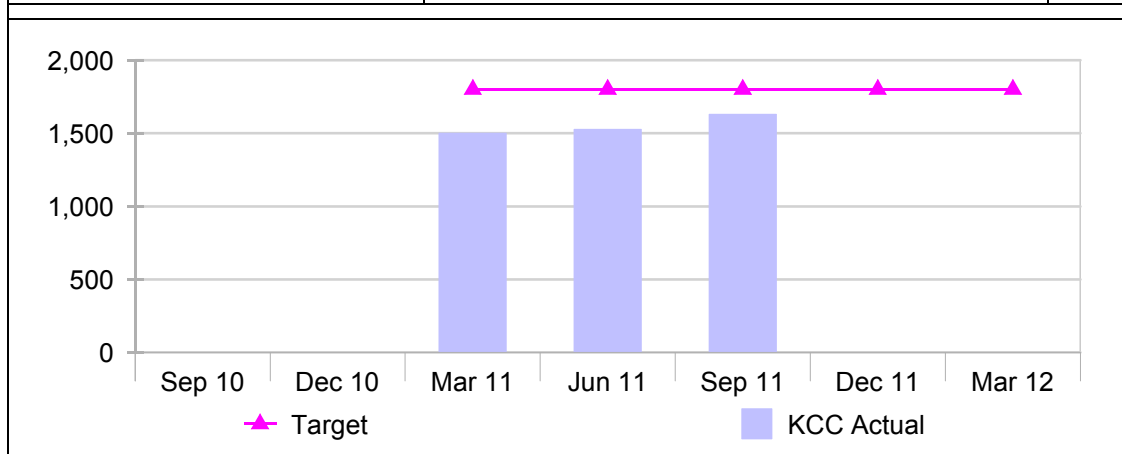
1. Operational teams' not understanding SWIFT (our client database) in relation to Telecare ; data-quality low.
2. Telecare equipment not meeting needs, client groups being missed out for use of Telecare.
3. Operational staff not identifying Telecare as a means of meeting assessed needs.

Action taken :

1. Telecare SWIFT training in place for staff and ongoing refresher training offered including floor walking as well as additional support for data quality.
2. Equipment needs reviewed through Teletechnology Strategy group and strategy and commissioning plan being developed.
3. Telecare covered as an ongoing topic in individual supervision, Personal Action Planning, and managers meetings. Monthly performance monitoring by Divisional Management Teams.

Number of adult social care clients receiving a telecare service	Green ↑
Discussion and actions agreed by PAT	

Number of adult social care clients provided with an enablement service		Amber	
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	Bold Steps Ambition	Put the Citizen in Control
Cabinet Member	Graham Gibbens	Director	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	Division	Older People and Physical Disability



Data Notes.
Tolerance: Higher values are better
Unit of measure: Number
Data Source: Adult Social Care Swift client system

Data is reported as number of clients accessing the service during the quarter.

No comparative data for other local authorities is available for this indicator.

Trend Data – number per quarter	Previous Year			Current Year			
	Sept 10	Dec 10	Mar 11	Jun 11	Sep 11	Dec 11	Mar 12
KCC Result			1,500	1,527	1,631		
Target per quarter			1,800	1,800	1,800	1,800	1,800
Rag Rating			Amber	Amber	Amber		

Commentary

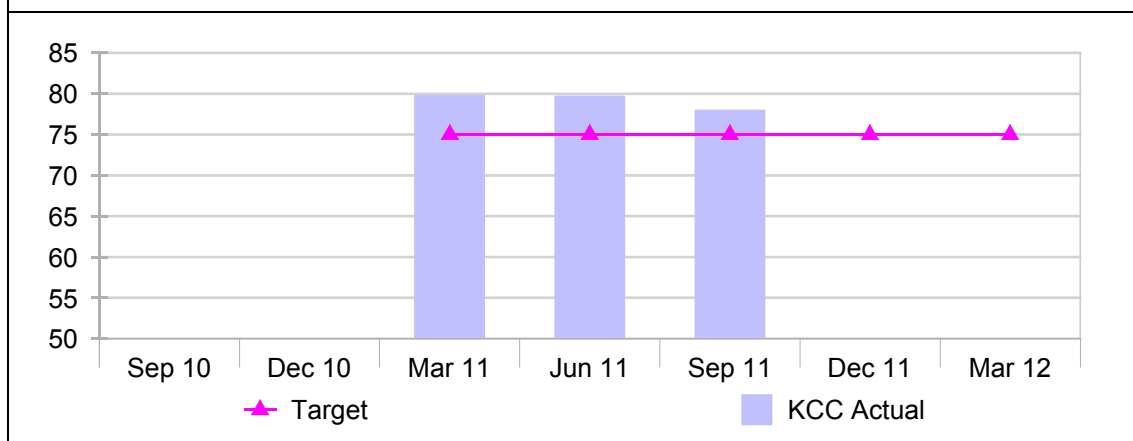
The number of clients provided with an enablement service has increased again this quarter but remains behind target. Enablement has been in place for over a year to support new client referrals to Adult Social Care.

Number of adult social care clients provided with an enablement service	Amber
<p>Past performance has shown the expected increase in enablement during its early development phase, with continued increases, although current numbers of people in receipt of enablement is lower than the 600 per month (1800 per quarter) set as the predicted level.</p> <p>All the assessment and enablement teams now have enablement services available for their locality.</p>	
<p>What actions are we taking to improve performance (and drivers of performance)</p>	
<p>Numbers are expected to increase in the future since more people are accessing enablement services as part of their assessments and people who are already receiving packages are now being referred to enablement services with the aim of increasing their independence. In addition, reasons for not receiving enablement are examined carefully. About 60% of people who do not receive enablement need the provision of equipment to allow them to live independently. Some localities are participating in an Occupational Therapy project which targets existing people in receipt of homecare and hopes to make them more independent with the provision of equipment. This is another form of an enabling service. Externally commissioned enablement services including the Active Care service are within the figures. Kent Enablement at Home is increasing its capacity to ensure that all demand is being met.</p> <p>An enablement review is being carried out to examine why people are not being referred or accepted into enablement schemes. Dependent on the findings, action will be put into place to address any issues where improvements can be made. Volumes of enablement are monitored on a monthly basis at Divisional and Directorate Management Teams. All heads of service and team leaders are proactively ensuring that enablement should be the main care pathway for all appropriate referrals.</p>	
<p>Risks and mitigating actions</p>	
<p>Enablement targets might not be met due to :</p> <ol style="list-style-type: none"> 1. Staff not referring. 2. Lack of enablement capacity or specialism (dementia). 3. Other enabling type services may meet the demand for enablement in other ways, such as provision of equipment or intermediate care. 4. Unrealistic expectations in relation to target numbers set (charging consultation and/ or efficiency savings may reduce referrals). <p>Action taken</p> <ol style="list-style-type: none"> 1. Enablement review being carried out, staff and teams monitored against target set. 2. Review of crisis services in East Kent carried out and new services proposed to be commissioned. 	

Number of adult social care clients provided with an enablement service	Amber
<p>3. Careful monitoring of all other services to evidence its impact in terms of outcomes for people and the enablement service.</p> <p>4. Review to identify changes in new cases and referral numbers and action to be taken from there.</p>	
Discussion and actions agreed by PAT	

Percentage of adult social care assessments completed within six weeks	Green
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Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	Bold Steps Ambition	Put the Citizen in Control
Cabinet Member	Graham Gibbens	Director	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	Division	Older People and Physical Disability



Data Notes.
 Tolerance: Neither too high nor too low
 Unit of measure: Percentage
 Data Source: Adult Social Care Swift client system

Data is reported as percentage rate achieved for each quarter.

No comparative data for other local authorities is currently available for this indicator.

Trend Data – quarterly data	Previous Year			Current Year			
	Sept 10	Dec 10	Mar 11	Jun 11	Sep 11	Dec 11	Mar 12
KCC Result			79.8%	79.7%	78.0%		
Target			75%	75%	75%	75%	75%
Rag Rating			Green	Green	Green		

Commentary
 Performance continues to be within good tolerance of the target level. The target level has been reviewed and now stands at 75%

Percentage of adult social care assessments completed within six weeks	Green
<p>with the aim to ensure that people do not spend too much time in an enablement service or are assessed too quickly.</p> <p>This indicator serves to ensure that we have the right balance between ensuring enablement is delivered effectively and ensuring the whole assessment process is timely. Factors affecting this indicator are linked to waiting lists for assessments, assessments not being carried out on allocation and some long standing delays in Occupational Therapy assessments. There are also appropriate delays due to people going through enablement as this process takes up to six weeks and the assessment can not be completed until the enablement process is completed</p>	
What actions are we taking to improve performance (and drivers of performance)	
<p>A review of unallocated cases is taking place through a Task and Finish Group of assessment and enablement managers and good practice in some localities is being shared and implemented.</p> <p>In addition to this, the support provided through enablement and the interaction with the staff providing the service, all contribute to the final assessment. The better the monitoring of the individual through this process, the more timely the assessment will be. Assessment completion dates are being reviewed and action proposed as directed by the outcome of the review.</p> <p>Comparison to other local authorities to be carried out in relation to enablement impacting on timelines for assessments. Future targets are to be defined based on enablement numbers, clinic work, AIG referrals, hospital team referrals and referrals not appropriate for enablement - these will be identified through the above Task and Finish Group.</p> <p>This key indicator is monitored on a monthly basis by Divisional and Directorate Management Teams.</p>	
Risks and mitigating actions	
<ol style="list-style-type: none"> 1. Unallocated cases not addressed, delaying assessment completion. 2. Kent Contact and Assessment Services (KCAS) changes affecting AIG referrals completion. 3. Task and Finish Group review outcomes not being addressed through action planning. <p>Action taken :</p> <ol style="list-style-type: none"> 1. Task and Finish Group in place. 2. Director for Older People and Physical Disability on the KCAS Project Group and a Service Level Agreement is being proposed. 	

Percentage of adult social care assessments completed within six weeks	Green
3. Divisional Management Team, heads of service, assessment and enablement managers, and individual staff responsibilities identified and progress monitored.	
Discussion and actions agreed by PAT	

Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review				Green ↑																					
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	Bold Steps Ambition	Put the Citizen in Control																						
Cabinet Member	Graham Gibbens	Director	Anne Tidmarsh																						
Portfolio	Adult Social Care and Public Health	Division	Older People and Physical Disability																						
<table border="1"> <caption>Chart Data</caption> <thead> <tr> <th>Quarter</th> <th>KCC Actual (%)</th> <th>Target (%)</th> </tr> </thead> <tbody> <tr> <td>Mar 11</td> <td>66%</td> <td>70%</td> </tr> <tr> <td>Jun 11</td> <td>71%</td> <td>70%</td> </tr> <tr> <td>Sep 11</td> <td>72%</td> <td>70%</td> </tr> <tr> <td>Dec 11</td> <td>73.5%</td> <td>70%</td> </tr> <tr> <td>Mar 12</td> <td>75%</td> <td>70%</td> </tr> </tbody> </table>			Quarter	KCC Actual (%)	Target (%)	Mar 11	66%	70%	Jun 11	71%	70%	Sep 11	72%	70%	Dec 11	73.5%	70%	Mar 12	75%	70%	<p>Data Notes. Tolerance: Higher values are better Unit of measure: Percentage Data Source: Adult Social Care Swift client system</p> <p>Data is reported as percentage for each quarter.</p> <p>No comparative data is currently available for this indicator.</p>				
Quarter	KCC Actual (%)	Target (%)																							
Mar 11	66%	70%																							
Jun 11	71%	70%																							
Sep 11	72%	70%																							
Dec 11	73.5%	70%																							
Mar 12	75%	70%																							
Trend Data – quarterly data		Previous Year			Current Year																				
		Sept 10	Dec 10	Mar 11	Jun 11	Sep 11	Dec 11	Mar 12																	
KCC Result				66%	71%	72%																			
Target				70%	71%	72%	73.5%	75%																	

Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review						Green ↑	
Rag Rating			Amber	Green	Green		
Commentary							
<p>The percentage of outcomes achieved has increased to 72% for this quarter and results are on target.</p> <p>2011. People’s needs and outcomes are identified at assessment and then updated at review, in terms of achievement and satisfaction.</p>							
What actions are we taking to improve performance (and drivers of performance)							
<p>Many people who contact Adult Social Care need information, advice and guidance, or the provision of fast track equipment. This key indicator is a relatively new way of recording information and results are monitored on a monthly basis at Divisional and Directorate Management Teams through the Locality Action Plans. These require Heads of Service to comment on and action performance improvement, as well as identify training needs and risks.</p> <p>The information will increasingly be used to support the process for development and commissioning of services.</p> <p>An action plan has been set linked to the Personal Budgets and Reviews action plans. The assessment and enablement managers Task and Finish group is leading on the system with cultural change be delivered to ensure delivery of the target.</p> <p>This to include: Hospital Teams when carrying out first review recording outcomes on SWIFT (the client database); Enablement services, when carrying out first review, ensuring outcomes are recorded or reported to the assessment officer for recording on SWIFT; Assessment officers and case managers recording of outcomes.</p> <p>The annual service user survey resulted in a national indicator relating to “Self reported experience of social care users”. The Families and Social Care Directorate are very aware that Kent’s performance was not as high as other councils and so continues to promote and monitor the achievement of people’s outcomes to ensure better performance in future.</p>							
Risks and mitigating actions							
<ol style="list-style-type: none"> 1. Target linked to accurate recording of reviews on SWIFT, data-quality risks. 2. Interdependency on achieving Personal Budgets and Review action plans. 							

<p>Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review</p>	<p>Green ↑</p>
<p>3. New target data-quality risks not fully known.</p> <p>Action taken :</p> <ol style="list-style-type: none"> 1. Part of the Review action planning lead by coordination managers' Task and Finish group. 2. See 1. The dependency of these action plans identified with responsibilities clearly set out. 3. Close monitoring by Divisional Management Teams and active involvement of data quality staff. 	
<p>Discussion and actions agreed by PAT</p>	
<p>This indicator has not been subject to discussion by PAT at this time.</p>	

FSC – Adults Half Year Monitoring – Exception Reporting**Sensory**

Project/ Development /key action	a/c manager	Link to Corporate/ Directorate Target or theme	Deliverables or outcomes planned for 2011/12	Target dates	Half Yr Monitoring Not on course/ not completed explanation
Complete Hi Kent and KAB reviews and commissioning of new services	Beryl Palmer	Active Lives, Bold Steps To put the citizen in control	Service redesign - development of new specifications	June 2011	Service reviews have been carried out on Hi Kent and KAB and rather than develop interim contracts/grant agreements it is proposed that a Sensory Commissioning strategy is completed first, followed by the development and implementation of a contracting plan. This and capacity issues has led to revised timescales.

Equipment

Project/ Development /key action	a/c manager	Link to Corporate/ Directorate Target or theme	Deliverables or outcomes planned for 2011/12	Target dates	Half Yr Monitoring Not on course/ not completed explanation
Review Home Support Fund (HSF) documentation and assessment practices.	Policy Team / Mark Hogan	Bold steps for Kent To help the Kent economy grow To put the citizen in control To tackle disadvantage Active Lives/ Vision for Kent	Consistent process and clear up to date guidelines.	April 2011 onwards	Joint working with the regional authorities, which has had an impact on target dates.

Learning Disability

Project/development/key action	a/c manager	Link to Corporate/ Directorate Target or theme	Deliverables or outcomes planned for 2011/12	Target dates	Half Yr Monitoring Not on course/ not completed explanation
Delivery of Valuing People Now in line with National Delivery Plan	Kent Partnership Board, Valuing People Now - Delivery Manager	Putting People First, Valuing People Now (including Cabinet Report). Bold steps To put the citizen in control To help the Kent economy grow To tackle disadvantage	Partnership Board Annual Report (as per DH Specification) incorporating JSNA, and other performance measures. Create and publish a Kent Valuing People Now - Delivery Plan	On going	Delivery Report pending approval

Older Person/ Physical Disability

Project/ Development /key action	a/c manager	Link to Corporate/ Directorate Target or theme	Deliverables or outcomes planned for 2011/12	Target dates	Half Yr Monitoring Not on course/ not completed explanation
Preparations for the county meals contract to let	Head of Strategic Commissioning and Heads of Service	Bold steps To put the citizen in control To help the Kent economy grow To tackle disadvantage	All documentation prepared and tendering process started to relet the contract in April 2012.	March 2012	Decision made to defer for 1 year
Domiciliary and enhanced domiciliary and community support	Head of Strategic Commissioning and Heads of Service	Bold steps To put the citizen in control	Tendering process undertaken and contract ready to let in April 2012	March 2012	Initial assessment completed and implementation postponed for 1 year.

services		To help the Kent economy grow To tackle disadvantage			
Review & Relet Home Support Contract to include Enablement and Active Care Force	Contract Manager	Bold steps To put the citizen in control To help the Kent economy grow To tackle disadvantage	To secure efficiencies in service delivery and the provision of services that promote the personalisation agenda Will support the new Health and well being Board and GP consortia	April 2012	Initial assessment completed and implementation delayed for 1 year to allow alignment of related contract activities

Equalities

Project/ development/ key action	a/c manager	Link to Corporate/ Directorate Target	Deliverables or outcomes planned for 2011/12	Half Yr Monitoring Not on course/ not completed explanation
There is increased satisfaction amongst key stakeholders and the community with services.	SMT	Bold steps To put the citizen in control To help the Kent economy grow To tackle disadvantage	Identify how we can link in with KCC's community engagement strategy.	Impact of the Kent wide re-organisation. This has identified as a key area for development before April 2012 by the FSC Directorate Equalities group.

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By: Head of Democratic Services

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 10 January 2012

Subject: **UPDATE ON SELECT COMMITTEE WORK**

Classification: Unrestricted

Summary: This report updates Members on current and future Select Committee work and invites suggestions for future Select Committee Topic Reviews.

Current Select Committee Review Work

1. The following reviews are in or nearing their closing stages:-

Educational Attainment at Key Stage 2 - The Select Committee, under the Chairmanship of Mr C T Wells, is looking at the reasons for variations in Key Stage 2 performance within Kent Schools, with a focus on schools in areas of deprivation.

After briefing sessions through the summer, successful visits to seven schools were undertaken during October and early November, and work undertaken by Directorates to gather insights from pupils and parents. Both have been well supported by schools. Feedback from this work and the visits was reported to the Select Committee in early December, and the Committee then discussed key issues and its areas of recommendation. The report will be written in the New Year, to go to Cabinet in April 2012 and then to the next available County Council.

The contacts in Democratic Services for this Select Committee are: Research Officer Pippa Cracknell (01622 694178) and Assistant Democratic Services Manager Denise Fitch (01622 694269).

The Student Journey - The Select Committee, under the Chairmanship of Mr K Smith, has now completed its evidence gathering sessions and drafted its recommendations. The report is currently being written and will be shared with the relevant Cabinet Members in March. The final report will be considered by Cabinet and County Council in May 2012.

The contacts in Democratic Services for this Select Committee are: Research Officer Gaetano Romagnuolo (01622 694292) and Democratic Services Officer Theresa Grayell (01622 694277).

2. The Select Committee on **Dementia**, under the Chairmanship of Mrs T Dean, submitted its final report to the County Council on 15 December 2011, where the report and its recommendations were welcomed and endorsed.

Future Select Committee work

3. A review on **Domestic Abuse** was suggested by the Customer and Communities POSC, meeting as the Crime and Disorder Committee in July 2011, and this proposal was welcomed and approved by the Scrutiny Board on 2 November. Preliminary research is underway and the review will commence in the New Year.

4. If Members have any suggestions of topics they would like to put forward for consideration for inclusion in the future topic review work programme, they should contact the Democratic Services Officer for this POSC.

Recommendation:-

5. Members are asked to note the review work currently coming to fruition, and future work soon to commence, and advise the Democratic Services Officer of any topics which they would like to put forward for consideration for inclusion in the future Select Committee Topic Review Work Programme.

Theresa Grayell
Democratic Services Officer

Background Information: *Nil*

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